

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb 4 MO.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Randolph Hills Nursing home		d. STREET ADDRESS 3123 Brooklawn Terrace	
3. NAME OF DECEASED (Type or print) Peter		4. DATE OF DEATH DEC 28 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/1880
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? N. Y.	
13. FATHER'S NAME Isaac Addis		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 043-26-4227	
17. INFORMANT Wife		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper respiratory infection viral + DUE TO (b) frankly bacterial. CONDITIONS, if any, which gave rise to immediate cause (c), stating the underlying cause last. 475x			INTERVAL BETWEEN ONSET AND DEATH 4 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 26, 1967 to Dec 28, 1967 that (I) (we) last saw the deceased alive on Nov 8, 1967 , and that death occurred at 8 P.M. from causes and on the date stated above.			
22a. SIGNATURE A. J. Connolly		22b. DATE SIGNED 12-28-67	
22c. PHYSICIAN'S NAME (Type) A. J. CONNOLLY - M.D.		22d. ADDRESS 1635 IRVINE ST. N.W. WASH. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-30-67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City or Town) (County) (State) Silver Spring Mont Md
24. FUNERAL DIRECTOR Robert A Pumphrey		25a. REC'D BY REGISTRAR DATE JAN 5 1968	
ADDRESS 7557 Wisconsin Ave Bethesda		25b. REGISTRAR'S SIGNATURE Charles J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]



CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Princess Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. STREET ADDRESS <u>312 Hospital Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Jaqueline Lois Akers</u>		4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 July 1959</u>
9. AGE (In years lost birthday) <u>8</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wayne J. Akers</u>		14. MOTHER'S MAIDEN NAME <u>Lois V. Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO (b) <u>Acute Pneumonia</u> DUE TO (c) <u>Cystic Fibrosis of the Pancreas</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8 Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>Dec. 1, 1967</u> , to <u>Dec. 5, 1967</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>Dec. 5, 1967</u> , and that death occurred at <u>9:43 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stuart Handwerger</u>		22b. DATE SIGNED M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>5 December 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stuart Handwerger, MD</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/8/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Norfolk, Virginia</u>	
24. FUNERAL DIRECTOR <u>Simiele Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u>		c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>COLONIAL VILLA NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHRISTINE</u> Middle <u>(NONE)</u> Last <u>ALEX</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-1966</u>
9. AGE (In years lost birthday) yrs. <u>71</u>		10. IF UNDER 1 YEAR Months Days Hours Mm. IF UNDER 24 HRS. Months Days Hours Mm.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Tripoli, Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Manetas</u>		14. MOTHER'S MAIDEN NAME <u>Mary (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Helen Sanidakas</u>		Address <u>10702 Woodsdale Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X METASTATIC CANCER IN LUNGS, CAUSE?</u> DUE TO (b) <u>PANCREATITIS, CHRONIC</u> DUE TO (c) <u>9 MONTHS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> , 19 <u>67</u> , to <u>12/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> , 19 <u>67</u> , and that death occurred at <u>12:30 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>James A. Roberts</u>		22b. DATE SIGNED <u>DEC. 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		22d. ADDRESS <u>8907 GEORGIA AVE. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 22, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>
24. FUNERAL DIRECTOR <u>Thomas J. Warner</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Warner</u>		25c. REGISTRAR'S NAME <u>James J. Warner</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MONTGOMERY COUNTY, MARYLAND											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>					
c. LENGTH OF STAY IN 1b <u>18 yrs</u>						d. STREET ADDRESS <u>4120 Stanford St</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4120 Stanford St</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>Nathan</u> Last <u>Alexander</u>						4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 22, 1910</u>		9. AGE (In years last birthday) <u>57</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>7</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrical engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Wharton, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MAX Alexander</u>						14. MOTHER'S MAIDEN NAME <u>Minnie Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>013-05-6897</u>		17. INFORMANT Address <u>Mrs. Eleanor Alexander</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the</u> <u>Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>151X</u> DUE TO (c) <u>4 years</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>March, 1963</u> , to <u>Dec 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 8, 1967</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>William Harvey</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>12/9/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>William Harvey</u>						22d. ADDRESS <u>2121 Penn Ave N.W.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12/11/67</u>			23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Park</u>			23d. LOCATION (City, town or county) (State) <u>Falls Church, Virginia</u>		
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u>						25a. REC'D BY REGISTRAR <u>DEC 15 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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Also Standard 24
also Standard 24

Samuel Nelson Alexander
M. J.

Max Alexander
Liberty Texas 1911

Mr. E. E. Alexander
Liberty Texas 1911

John Alexander
Liberty Texas 1911

John Alexander
Liberty Texas 1911

John Alexander
Liberty Texas 1911

John Alexander
Liberty Texas 1911

John Alexander
Liberty Texas 1911

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING, MD.	c. LENGTH OF STAY IN 1b 2 1/2 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		d. STREET ADDRESS 3229 University Blvd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) AHMED ALHASHIMI		4. DATE OF DEATH Month 12 Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/62
9. AGE (In years last birthday) yrs. 5		IF UNDER 1 YEAR Months 12 Days 12 Hours 19 Min. 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IRAQ	12. CITIZEN OF WHAT COUNTRY? IRAQ
13. FATHER'S NAME KHALID ALHASHIMI		14. MOTHER'S MAIDEN NAME unobtainable	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. A. Youssef-		Address 4009 Dearfield Ave. Kensington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme Injuries DUE TO (b) including fractured skull DUE TO (c) and cerebral laceration			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child ran into street in front of auto and was struck	
20c. TIME OF INJURY Month, Day, Year 11:50 a.m. 12-12-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, for street, office, etc.) Street
20f. (City or town) Kensington (County) Montgomery (State) Md.		20g. (City or town) Kensington (County) Montgomery (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap		22. DATE SIGNED DEC. 12, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City or town, county) Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 12/14/67	23c. NAME OF CEMETERY OR CREMATORY National Mem. Park	23d. LOCATION (City or Town) (County) (State) Falls Church, Va.
24. FUNERAL DIRECTOR The H.H. Hines Co.		25a. REC'D BY REGISTRAR DATE DEC 15 1967	
ADDRESS 2901 14th St. NW.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>		d. STREET ADDRESS <u>2411 Darrow Street</u>	
3 NAME OF DECEASED (Type or print) First <u>HAZEL</u> Middle <u>WURENE</u> Last <u>ALLEN</u>		4 DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-26-1899</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <u>68</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>Christiansburg, Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Noah Cole</u>		14 MOTHER'S MAIDEN NAME <u>Lucie (Unknown)</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>578-07-5110-A</u>	
17 INFORMANT <u>Thomas J. Allen</u>		Address <u>2411 Darrow Street Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> , 19 <u>65</u> , to <u>12/27</u> , 19 <u>67</u> , that (we) lost sow the deceased alive on <u>12/27</u> , 19 <u>67</u> , and that death occurred at <u>3 A</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Norman H. Rubenstein</u>		22b. DATE SIGNED <u>12/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman H. Rubenstein</u>		22d ADDRESS <u>11161 New Hampshire Avenue, S. S. Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR (Type) <u>C. Glen Carter</u>		25a REC'D BY REGISTRAR <u>11/34</u>	
25b REGISTRAR'S SIGNATURE <u>John Judge</u>		DATE <u>JAN 4 1968</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15
20 M 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17122

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instituton: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>7 MONTHS</u>		d. STREET ADDRESS <u>702 Venice Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Gertrude BELLE Andrews</u>		4 DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>SEPT. 20, 1871</u>
9 AGE (In years lost birthday) <u>96</u> yrs.		10 IF UNDER 24 HRS. Months <u>5</u> Days <u>12</u> Hours <u>12</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>218-54-5096</u>	
17. INFORMANT <u>Daughter - Mrs. Thos. Perkins</u>		Address <u>702 Venus Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>Hypertension</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>3 Dec.</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4 Dec.</u> 19 <u>67</u> and that death occurred at <u>9:55 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William D. And</u>		22b. DATE SIGNED <u>12/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM D AND</u>		22d. ADDRESS <u>7006 COLEVILLE RD. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/7/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON COX</u>	23d. LOCATION (City or town) (County) (State) <u>KILGUS RD. THANSPVILLE, MD.</u>
24 FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC.</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1967</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17123

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York.</u> b. COUNTY <u>Dutchess</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington.</u>		c. LENGTH OF STAY IN 1b <u>18 months.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Catfoll Hall Nursing Home.</u>		d. STREET ADDRESS <u>Red Hook. N.Y.</u>	
3 NAME OF DECEASED (Type or print) <u>Adelaide Elting Arnold.</u>		4 DATE OF DEATH <u>December 30 19 67</u>	
5 SEX <u>Fe.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 15/1882</u>
9 AGE (In years last birthday) <u>85 yrs</u>		10 UNDER 1 YEAR <u>30</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home.</u>	
11 BIRTHPLACE (State or foreign country) <u>New York.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry S Elting</u>		14. MOTHER'S MAIDEN NAME <u>Sara J. Pitcher.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>Elting Arnold. 4919 Dorset Ave. Chas. Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Inefficiency.</u> (b) <u>Cardio-Vascular Disease.</u> (c) <u>4201</u> DUE TO <u>Cardio-Vascular Disease.</u>		INTERVA. BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, or other disposition <u>Burial</u>		23b. DATE THEREOF <u>1-3-68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St James Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Hude Park New York</u>	
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>		25a. REC'D BY REGISTRAR <u>JAN 5 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>12/30/67.</u>	

Bain, Rosalind

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

7124

17124

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>26 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>0210 Flower Avenue</u>		d. STREET ADDRESS <u>0210 Flower Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Rosalind</u> Middle <u>Moore</u> Last <u>Bain</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 13, 1867</u>
9. AGE (In years last birthday) <u>98</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>47</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph B. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Amelia H. Prettyman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>David P. Moore</u>		Address <u>9210 Flower Avenue Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Generalized arterio sclerosis</u> DUE TO (c) <u>Several years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>to December 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>December 20, 1967</u> , and that death occurred at <u>9:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>		22b. DATE SIGNED <u>December 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>Dec. 23, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>		25c. ADDRESS <u>8434 Maria Avenue Silver Spring, Md.</u>	

CERTIFICATE OF DEATH

17125

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN lb <u>2 mos</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5801 Namakagan Road</u>	
3 NAME OF DECEASED (Type or print) <u>Delia Ferrari Baldaccini</u>		4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-24-1882</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carlo Ferrari</u>		14. MOTHER'S MAIDEN NAME <u>Felicita Cherubini</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>578-68-7321-51</u>	
17 INFORMANT <u>Keo Goss-Daughter- See Item No. 9</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>12 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 14</u> , 19 <u>67</u> to <u>Dec 14</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Dec 14</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> P.M. from causes on and the date stated above.			
22a. SIGNATURE <u>Robert C. Macdon</u> M.D.		22b. DATE SIGNED <u>12/14/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-16-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. RECEIVED BY REGISTRAR <u>DEC 16 1967</u>	
ADDRESS <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

71
closed with medical examiner

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
17126									
1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c LENGTH OF STAY IN b <u>1 hr. 20 min.</u>					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Hyatt.</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>20783</u>				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>					d STREET ADDRESS <u>7610 - 25th ave.</u>				
3 NAME OF DECEASED (Type or print) <u>EVA</u>					4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1967</u>				
5 SEX <u>F</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1893</u> <u>3-27-93</u>		9 AGE (In years lost birthday) <u>74</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Canada</u>			12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Thomas Martell</u>					14 MOTHER'S MAIDEN NAME <u>Amanda Tourpin</u>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>212-56-2421</u>		17 INFORMANT <u>Martha Petrone - dgt</u> Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Hypertensive & arteriosclerotic CVD.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that <u>U</u> (this hospital) attended the deceased from <u>1955</u> , 19 <u>55</u> to <u>12-27, 1967</u> , that <u>U</u> (we) last saw the deceased alive on <u>12-20</u> 19 <u>67</u> , and that death occurred at <u>12-20</u> from causes and on the date stated above.									
22a SIGNATURE <u>R. D. Bauer M.D.</u>					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>12-27-67</u>		
22c PHYSICIAN'S NAME (Type) <u>R. D. Bauer, M.D.</u>					22d ADDRESS <u>2513 Buck Lodge Rd. Oak Park, Md.</u>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>12/30/67</u>		<u>Cedar Hill Cemetery</u>		<u>Suitland, Md.</u>			
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>					ADDRESS <u>Mt. Rainier, Maryland</u>		25a REC'D BY REGISTRAR <u>JAN 2 1968</u> 25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		



CERTIFICATE OF DEATH

17127

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>10104 BURNETT AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY</u>		4. DATE OF DEATH <u>December 8, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAILER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROGGER</u>	9. AGE (in years last b. day) <u>69</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MORRIS</u>		14. MOTHER'S MAIDEN NAME <u>LEAH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>215-07-8425</u>	17. INFORMANT <u>Martin Baltrotsky</u> Address <u>1801 Arcola Ave. Silver Spring,</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal Papillary necrosis</u> DUE TO (b) <u>Diabetes</u> DUE TO (c) <u>5 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic thrombotic thrombocytopenic purpura</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 4</u> , 19 <u>67</u> , to <u>Dec 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 8</u> , 19 <u>67</u> , and that death occurred at <u>3:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/9/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. EIG</u>		22d. ADDRESS <u>8641 Colson Rd. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u>
24. FUNERAL DIRECTOR <u>Donald M. Stein</u> ADDRESS <u>232 Carroll St., N.W. - Wash., D.C.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEC 12 1967

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17128

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hyattsville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>Hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>7333 New Hampshire Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Ernest P. Barbour</u>		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1910</u> <u>5/25/1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. Prtg. Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philip J. Barbour</u>		4. MOTHER'S MAIDEN NAME <u>Ida G. Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>216-44-9552</u>	
17. INFORMANT <u>Mrs. Mary Bennett - (Sister-in-law)</u>		Address <u>7300-Birch Ave., Tak. Pk., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>194</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple Extreme Internal Injuries with Exsanguination</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased, driver, hit median strip</u> <u>lost control of car & struck pole</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:30 a.m. 12-24-1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Hyattsville D.C. Geo., Md.</u>	
21. I certify that I took charge of the remains described above, he'd an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>DEC. 25, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		Address (Street, city, town, or county) <u>Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25. REC'D BY REGISTRAR <u>JAN 3 1968</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17133

17129

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN It 58 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) / a. STATE Virginia		b. COUNTY Manassas	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital						d. STREET ADDRESS 251 King George Drive			
3. NAME OF DECEASED (Type or print) First Middle Last Marion Carlton BARNES						4. DATE OF DEATH Month Day Year December 13 19 67			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jul. 15, 1921		9. AGE (in years last birthday) yrs 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USMC				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Eureka, North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leslie Norman Barnes						14. MOTHER'S MAIDEN NAME Eva Sthrother			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1942-1967				16. SOCIAL SECURITY NO 240 01 1458		17. INFORMANT Mrs. Nancy J. Barnes, 251 King George Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic necrosis massive, with bleeding DUE TO diathesis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Idiopathic thrombocytopenic purpura									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 16, 1967, to Dec. 13, 1967, that (he) (we) last saw the deceased alive on Dec. 13, 1967, and that death occurred at 855A M, from causes and on the date stated above									
22a. SIGNATURE Ross B. Moquin						M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 13, 1967	
22c. PHYSICIAN'S NAME (Type) Ross B. Moquin, M. D.						22d. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/15/67		23c. NAME OF CEMETERY OR CREMATORY Stonewall Memory Gardens		23d. LOCATION (City or Town) (County) (State) Manassas, Virginia			
24. FUNERAL DIRECTOR Falls Church Funeral Home 1102 West Broad Street, Falls Church, Virginia						25a. REC'D BY REGISTRAR DEC 18 1967		25b. REGISTRAR'S SIGNATURE J. Lewis Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2-3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D. C. b. COUNTY Washington				
c. LENGTH OF STAY IN 1b 47 1/2					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home					d. STREET ADDRESS 620 Princeton Place, N. W.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3 NAME OF DECEASED (Type or print) First Middle Last Elmore Loveing Barnett					4 DATE OF DEATH Month Day Year December 2 19 67				
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/18/1886		9. AGE (In years lost birthday) 81 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Massies Mill, Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Barnett					14. MOTHER'S MAIDEN NAME Sylvia Barnett				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 579-60-5899		17. INFORMANT Wife Loretta Barnett		18. ADDRESS 620 Princeton Pl W Wash, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from November 20, 1967 , to December 2, 1967 , that (I) (we) lost the deceased alive on November 28, 1967 , and that death occurred at 2 P.M. , from causes and on the date stated above.									
22a. SIGNATURE Myron Lenkin					22b. DATE SIGNED December 2, 1967				
22c. PHYSICIAN'S NAME (Type) Myron Lenkin					22d. ADDRESS University Nursing Home Wheaton, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12/6/1967		23c. NAME OF CEMETERY OR CREMATORY Harmony MEM Cemetery		23d. LOCATION (City or Town) (County) (State) Landover P G Co Md			
24. FUNERAL DIRECTOR William Spangler					25. REC'D BY REGISTRAR Charles Judge				
25a. ADDRESS 524 8th St N.E. Wash, D.C.					25b. REGISTRAR'S SIGNATURE Charles Judge				
DATE DEC 5 1967									

CERTIFICATE OF DEATH

17131

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a STATE <u>Virginia</u> b COUNTY <u>Fairfax</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>4 hrs 30 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>First Rutledge Middle Birmingham Last BARRY</u>		4 DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1896</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>New York City, N. Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Barry</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Birmingham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO <u>081-03-9166</u>	
17 INFORMANT <u>Mrs. Helen Stuber, 10117 Spring Lake</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Occlusive coronary arterio-sclerotic disease</u> 4201 DUE TO (b) <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>8 December 1967</u> to <u>8 December 1967</u> , that (1) (we) last saw the deceased alive on <u>8 December 1967</u> , and that death occurred at <u>0805 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert E. Gulde</u>		22b. DATE SIGNED <u>9 Dec. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Naval Hospital, Bethesda, Md.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Warrenton Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Warrenton Va.</u>
24. FUNERAL DIRECTOR <u>Moser Funeral Home</u> <u>Warrenton, Virginia</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 12 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, which should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/62

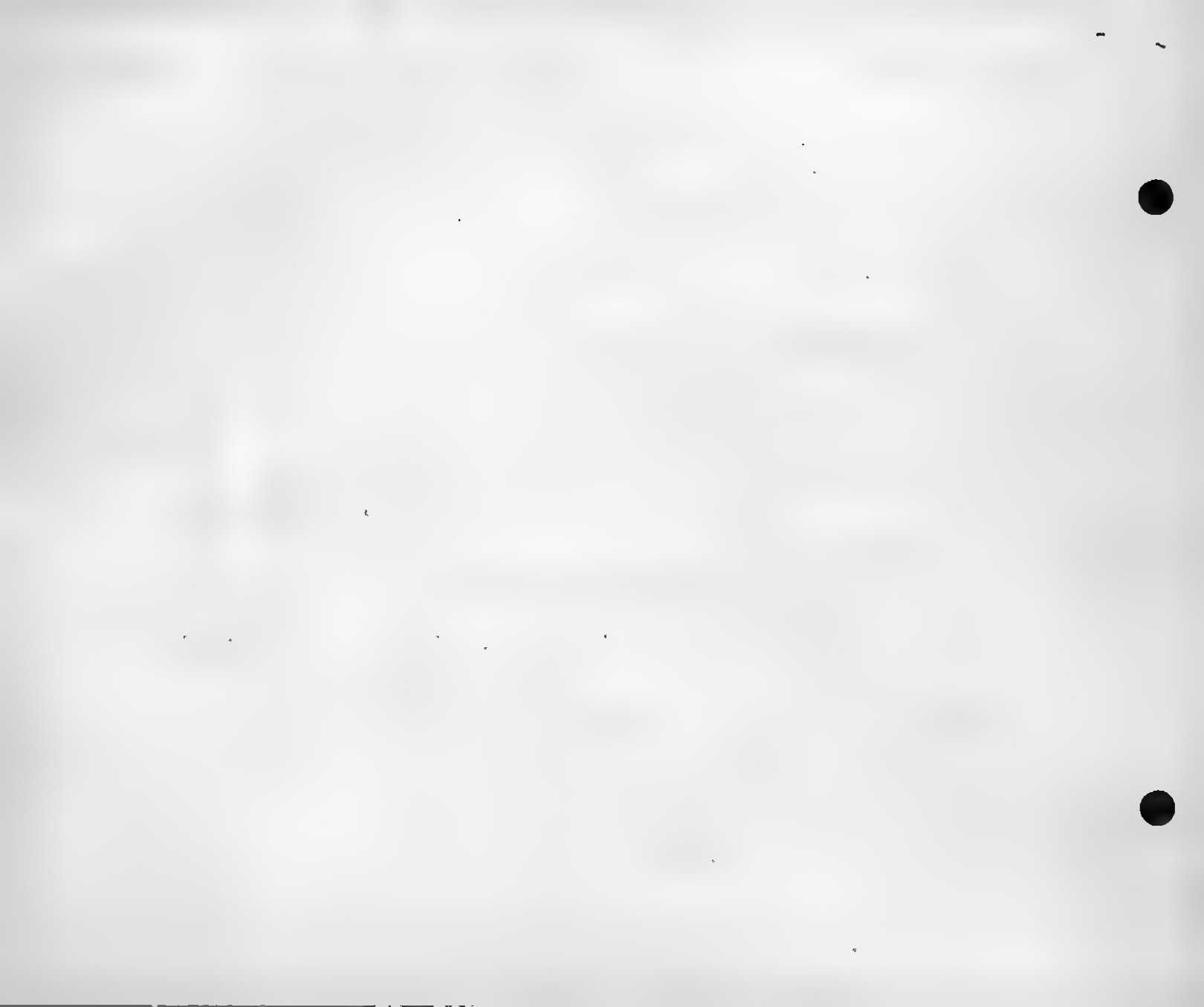
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17132

17132

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN lb 7 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		d. STREET ADDRESS 4500 WINDSOR LANE	
3 NAME OF DECEASED (Type or print) TRESSA M BEALL		4. DATE OF DEATH Month DEC Day 12 Year 1967	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/07 9 AGE (In years lost birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Murray - Kentucky		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John C. Oliver		14. MOTHER'S MAIDEN NAME Edwina (Unknown)	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Husband		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Bronchopneumonia, bilateral severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 471X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH week	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Meningeoma, right fronto-parietal area, residual (Craniotomy 1963)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 11, 1967 , to Dec. 12, 1967 , that (I) (we) last saw the deceased alive on Dec. 11, 1967 , and that death occurred at M , from causes and on the date stated above.			
22a SIGNATURE Philip H. Varner		22b DATE SIGNED 12-12-67	
22c PHYSICIAN'S NAME (Type) PHILIP H. VARNER		22d ADDRESS 10620 Georgia Ave, Silver Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12-14-67	23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY,		25a REC'D BY REGISTRAR DEC 15 1967	
ADDRESS Bethesda, Maryland		25b REGISTRAR'S SIGNATURE William J. Young	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17133

17133

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if installed in Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Germantown</u>		c LENGTH OF STAY IN TB <u>11 Months</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 2, Ristleford Rd.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Audry</u> Middle <u>Naomi</u> Last <u>Beckwith</u>		4 DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1967</u>	
5 SEX <u>Fe.</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct 24 1940</u>
9 AGE (In years last birthday) <u>27</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b KIND OF BUSINESS OR INDUSTRY	
12a BIRTHPLACE (State or foreign country) <u>Maryland</u>		12b CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>Woodward. HORS.</u>		14 MOTHER'S MAIDEN NAME <u>Annie-</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT <u>Father - Box 2 - Ristleford Rd Germantown</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Strangulation</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 MIN - -</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Husband strangled her.</u>	
20c TIME OF INJURY Month, Day Year Hour a.m. <u>10</u> p.m. <u>12/4</u> 1967		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>Trailer</u>	
20e PLACE OF INJURY (Home, farm, factory, street, office, b.d.g., etc.) <u>Rural Germantown Montgomery Md.</u>		20f (City or town) (County) (State) <u>Rural Germantown Montgomery Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		22. DATE SIGNED <u>Dec - 4, 1967</u>	
EXAMINER'S NAME (Type) <u>John S. Ball</u>		Address (Street, city, town, or county) <u>Rockville, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>Dec. 9, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Germantown Montg. Md.</u>	
24 FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a REC'D BY REGISTRAR <u>DEC 8 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1133

17134

1 PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>11/26/67-12/6/67</u>		d. STREET ADDRESS <u>P.O. Box 1042</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank J. Begley</u>		4. DATE OF DEATH <u>12 6 19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/88</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret. Business</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Begley</u>		14. MOTHER'S MAIDEN NAME <u>Callie Begley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>226-16-2139-A</u>	
17. INFORMANT <u>Street, Ave. Rock</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Cardiovascular Collapse</u> DUE TO (b) <u>Aspiration gastric contents</u> DUE TO (c) <u>Cerebral arterio sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>11/26</u> , 19 <u>67</u> , to <u>12-6</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>12-6</u> , 19 <u>67</u> , and that death occurred at <u>6:00</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>M. W. Shapiro</u>		22b. DATE SIGNED <u>12-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. W. Shapiro</u>		22d. ADDRESS <u>8107 Eastern Ave., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/9/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Maggie Smith Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Jonesville, Va.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler F. H.</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17135

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>38</u> hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		473	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>7611 Georgia Avenue, N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Elizabeth Ruth Belsey</u>				4 DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-3-90</u>	9. AGE (in years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>William Ziegler</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Oberglock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-50-6417</u>		17. INFORMANT <u>Patinet's chart</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE - UREMIA</u> DUE TO (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>4 MONTHS</u> <u>2 YEARS</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RHEUMATOID ARTHRITIS - DEFORMING</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>VAN</u> , 19 <u>66</u> , to <u>DEC 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>DEC 13</u> 19 <u>67</u> , and that death occurred at <u>2:30</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Robert L. Krichmar</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>				22d. ADDRESS <u>7733 ALASKA AVENUE N.W. WASH. D.C. 20014</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-19-67, Woodlawn Cem</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>New York NY</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>W & H Funeral Home</u>				25a. REC'D BY REGISTRAR <u>5733 44 Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

DATE DEC 21 1967

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS Simpsonville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) En route		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hamilton Lewis Bennett		4. DATE OF DEATH Month 12 Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-30
9. AGE (in years last birthday) 37 yrs		10. IF UNDER 1 YEAR Months 12 Days 24 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mail handler		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Bennett		14. MOTHER'S MAIDEN NAME Oxno Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Florence Bennett, Rte. 32, Simpsonville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation due to aspiration of blood DUE TO (b) from ruptured esophageal varices. DUE TO (c) Severe fatty infiltration of liver PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Severe fatty infiltration of liver			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Deceased vomited and aspirated vomitus.	
20c. TIME OF INJURY Month, Day, Year 4:15 PM 12-24 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Simpsonville Howard Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Beloen R. Yeap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELOEN R. YEAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED DEC. 24 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Robert L. Snowden		ADDRESS Rockville, Maryland	
25a. REC'D BY REGISTRAR JAN 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS 15 (4)
MAY 1967

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17137

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SANITARIUM + HOSPITAL		d. STREET ADDRESS 415 E. UNIVERSITY BLVD.	
3. NAME OF DECEASED (Type or print) First Middle Last HAROLD JESSE BERNEY		4. DATE OF DEATH Month Day Year DECEMBER 19 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/9/98
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial ARTIST		10b. KIND OF BUSINESS OR INDUSTRY PATRICK SIGNS Co	
11. BIRTHPLACE (County & State, or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Constrictive Heart Failure DUE TO (b) Calcific Aortic Stenosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH 3 days Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Pulmonary Emphysema			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-9- , 19 67 , to 12-19- , 19 67 , that (I) (was) last saw the deceased alive on 10-19- , 19 67 , and that death occurred at 3:05 PM , from causes and on the date stated above.			
22a. SIGNATURE SA Hillman		22b. DATE SIGNED 12/19/67	
22c. PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN, MD		22d. ADDRESS 8829 FLOWER AVE SILVER SPRING, MD 20901	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 22, 1967	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DEC 27 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	



1142

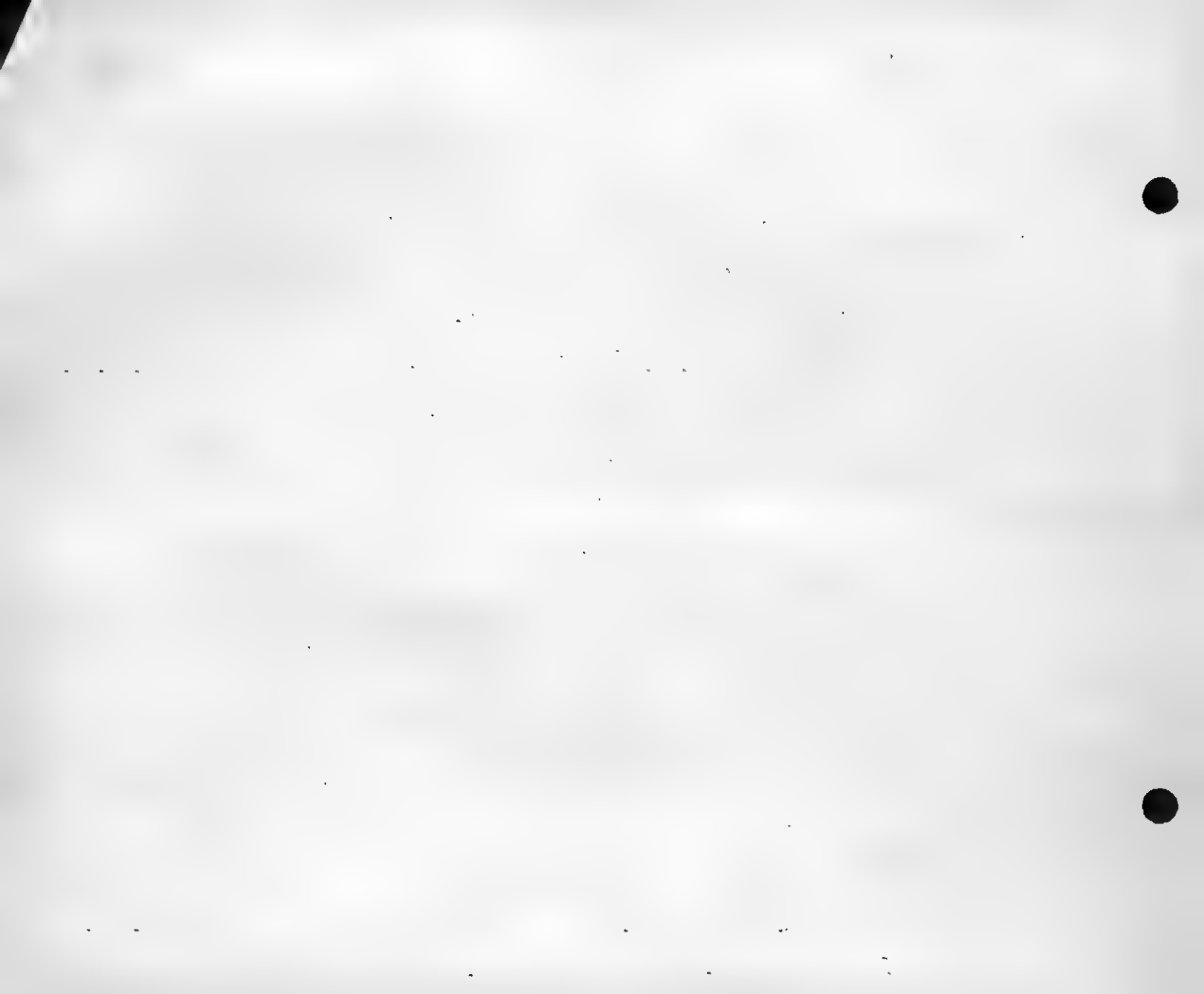
CERTIFICATE OF DEATH

17138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Belden Neape 12/26/67

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>5 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11919 Old Columbia Pike</u>		d. STREET ADDRESS <u>11919 Old Columbia Pike</u>	
3. NAME OF DECEASED (Type or print) <u>HEWRY L Berry</u>		4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1891</u>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Train conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D. C. Transit</u>	9. AGE (in years last birthday) <u>76 years</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wesley Berry</u>		14. MOTHER'S MAIDEN NAME <u>Dora Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-46-5611</u>	
17. INFORMANT <u>William Marlowe</u>		Address <u>4416 9th Street</u> <u>Theater, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Generalized Atherosclerosis</u>		INTERVAL BETWEEN DEATH AND DEATH <u>8 Mon</u> <u>104m</u> <u>154m</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis & Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>67</u> to <u>12/14</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/10</u> <u>1967</u> , and that death occurred at <u>6:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Warren</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>		22d. ADDRESS <u>Laurel Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	23b. DATE THEREOF <u>Dec. 22, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Mausoleum</u>	23d. LOCATION (City or town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>Mr. B. Thomas Johnson</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>	
ADDRESS <u>8134 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17139

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i>				b. COUNTY <i>Mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton, Md.</i>				c. LENGTH OF STAY IN 1b <i>2 yrs.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>University Nursing Home</i>								d. STREET ADDRESS <i>1401 BLAIR MILL Rd.</i>			
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>BITTNER</i> Last <i>BITTNER</i>				4. DATE OF DEATH Month <i>December</i> Day <i>29</i> Year <i>1967</i>				b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>CAUS</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-14-90</i>		9. AGE (In years last birthday) <i>77 1/2</i> yrs.		IF UNDER 1 YEAR Months <i>12</i> Days <i>10</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Dobois, Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>E. Pinley Clark</i>						14. MOTHER'S MAIDEN NAME <i>Sarah Reisinger</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>57-11-11765</i>		17. INFORMANT <i>K. Bittner</i> Address <i>1901 August St. Silver Spring, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> -341 DUE TO (b) <i>Viral Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Congestive Heart Failure (Atherosclerosis)</i>										INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> <i>18 days</i> <i>2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Vascular accidents - Senility</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>9-1</i> , 1967 to <i>Dec 29</i> , 1967, that (I) (we) last saw the deceased alive on <i>Dec. 29</i> 1967, and that death occurred at <i>7:30</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Philip E. Jones</i>								M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/29/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Philip E. Jones MD</i>								22d. ADDRESS <i>800 Parkway Drive Silver Spring, Md 20902</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>Jan. 2, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Clawwood Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Washington, D.C.</i>					
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey Inc.</i>						ADDRESS <i>8434 Georgia Ave. S.S.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17140

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>151</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>4216 Leland St</u>	
3 NAME OF DECEASED (Type or print) <u>Marelda P. Blanchard</u>		4 DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-14-06</u>
9 AGE (In years last birthday) <u>61</u> yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Piano Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Nebraska</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Bruce Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Madeline Harding</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>No</u>	
17 INFORMANT <u>Mr. Wendell Blanchard - above</u>		Address <u>(husband)</u>	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Adenocarcinoma, breast</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>66</u> , to <u>2000-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>22 Dec 10</u> 19 <u>67</u> , and that death occurred at <u>6:30</u> P.M. from causes and on the date stated above			
22a. SIGNATURE <u>William Henry Killey</u>		22b. DATE SIGNED <u>10-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William H. Killey</u>		22d. ADDRESS <u>8218 Wisc. Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>12/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREM.</u>	23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD.</u>
24. FUNERAL DIRECTOR <u>Joseph Tambore</u>		25a. REC'D BY REGISTRAR <u>Charles Jones</u>	
ADDRESS <u>Southern Washington DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	
DATE <u>DEC 15 1967</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First MARK			Middle A.			Last BLUME			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year 1967 MATED <input checked="" type="checkbox"/> December 18			2b. HOUR UNK M				
3. SEX male		4. RACE white		5. DATE OF BIRTH JULY 11, 1944		6. AGE (in years last birthday) 23 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year April 13, 1968			2d. HOUR UNKM				
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md							
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STUDENT				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington, D.C.				13b. COUNTY Washington				13c. CITY OR TOWN Washington				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER 4101 Cathedral Ave. N.W.			
14. FATHER'S NAME First Middle Last Jack Paul Blume						15. MOTHER'S MAIDEN NAME First Middle Last Ethel Nelson													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16b. SOCIAL SECURITY NO (If yes give war or dates of service) 217-44-9773						17. INFORMANT ADDRESS MR. JACK PAUL BLUME 1612 K ST. N.W. WASH. D.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month Day Year HOUR A.M. UNK P.M. 12/18 1967						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) apparently drowned							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) water						21f. LOCATION Street or R.F.D. No City or Town County State Bethesda, Montgomery, Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Werner U. Spitz, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town or county)						22b. DATE SIGNED 4/17/68							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 4/17/68				23c. NAME OF CEMETERY OR CREMATORY Greenmount				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland							
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland						25a. REC'D BY REGISTRAR APR 18 1968				25b. REGISTRAR'S SIGNATURE Charles J. Jager									

CERTIFICATE OF DEATH

17141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> <u>3224 Bankmore Ave</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN lb <u>3 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Hospital</u>		d. STREET ADDRESS <u>3301 Rutgers Street</u> <u>Beltsville, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>A.</u> Last <u>BOISEAU</u>		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PATRICK DOUGHERTY</u>		14. MOTHER'S MAIDEN NAME <u>BRIDGET HAMILTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-34-5337</u>	
17. INFORMANT <u>Edmond J. Dougherty</u>		Address <u>3301 Rutgers St.</u> <u>Beltsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHIAL PNEUMONIA</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19, 1967</u> to <u>Dec 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 25, 1967</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>MD Lenbin</u>		22b. DATE SIGNED <u>12-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Myron L. Lenbin</u>		22d. ADDRESS <u>2309 Shorefield Road, Beltsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Thomas J. Shugart</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Thomas J. Shugart</u>		25c. REGISTRAR'S SIGNATURE <u>Thomas J. Shugart</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17142

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN TB Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2226 Washington Avenue		d. STREET ADDRESS 2226 Washington Ave.	
3 NAME OF DECEASED (Type or print) ROSE BOJANKOSKY		4 DATE OF DEATH Month 12 Day 26 Year 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-3-95
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gershon Gottlieb		14. MOTHER'S MAIDEN NAME Sarah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Louis Bojan (SON)		Address Bethesda, Md. 7005 Loch Lomond Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Heart disease (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/26/67 , 19 67 , to 12/26/67 , 19 67 , that (I) (we) last saw the deceased alive on 12/26/67 , 19 67 , and that death occurred at 3:30 PM , from causes and on the date stated above			
22a. SIGNATURE Bernard J. Walsh		22b. DATE SIGNED 12/26/67	
22c. PHYSICIAN'S NAME (Type) BERNARD J. WALSH		22d. ADDRESS 1800 Eye St. N.E.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-28-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	23d. LOCATION (City or Town) (County) (State) Hyattsville, Maryland
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		25a. REC'D BY REGISTRAR DEC 29 1967	
3501 14th St. N. W. Washington, DC 20010		25b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17143

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN Tb <u>2 DAYS</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>Montgomery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN ECHO</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>						d. STREET ADDRESS <u>5900 OXFORD ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LAWRENCE OLIVER BOLTON, SR.</u>						4. DATE OF DEATH Month <u>DEC.</u> Day <u>4</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/6/1894</u>		9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR Months Days Hours Mm.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT. EMPLOYEE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND, GAITHERSBURY</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEWIS EDWARD BOLTON</u>						14. MOTHER'S MAIDEN NAME <u>ADEN, IDA L.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-32-4331</u>		17. INFORMANT Address <u>RUTH BOLTON - WIFE - SAME</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u> </u> , to <u>19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/16/67</u> , and that death occurred at <u>SUB</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u> M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <u>4/2/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>LEWIS E. D. D. M.</u>						22d. ADDRESS <u>4417 W. 1st St.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>				23d. LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>			
24. FUNERARY DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>						25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 17 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED WITH MEDICAL EXAMINER, BAL

MONTGOMERY STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING MD					c. LENGTH OF STAY IN 1b 15 YEARS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DIED AT HOME					d. STREET ADDRESS 9000 KIMES ST				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First EVA Middle BOMSTEIN Last BOMSTEIN					4. DATE OF DEATH Month 12 Day 19 Year 1967				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APPROX 1887	9. AGE (in years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (State or foreign country) RUSSIA			12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME JACOB GROSMAN					14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 218-52-9096			17. INFORMANT SANFORD BOMSTEIN			Address 9000 KIMES ST. SIL SPR. MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH IMMED.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 52 to Dec 67 , that (I) (we) last saw the deceased alive on 12-19-1967 , and that death occurred at 7:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE Bernard A. Fitzgerald M.D.					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12-19-67		
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD					22d. ADDRESS 217 UNION BLVD. SILVER SPRING MD				
23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL			23b. DATE THEREOF 12/22/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.		23d. LOCATION (City, town, or county) (State) HYATTSVILLE, MD.		
24. FUNERAL DIRECTOR'S SIGNATURE Deborah Fickel					ADDRESS 4217-9 E. ST.		25a. REC'D BY REGISTRAR DEC 26 1967		25b. REGISTRAR'S SIGNATURE W. J. Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 (page 5 may be retained for your files).
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>506 Tulip Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Andrew Joseph Bragg</u>		4 DATE OF DEATH <u>12 - 4</u> 19 <u>67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-3-30</u> 19 <u>37</u>
9 AGE (in years, months, and days) <u>37</u> yrs.		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Window Washer</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13 FATHER'S NAME <u>Unknown</u>		4 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>228-32-6674</u>	
17 INFORMANT <u>wife</u>		Address <u>Same as Item 2.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration & Contusion of Brain</u> DUE TO (b) <u>Fracture of Skull - due to fall from scaffold</u> DUE TO (c) <u>Sudden</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fall off scaffold when climbing windows</u>	
20c TIME OF INJURY Month, Day, Year <u>8:15 PM 12-4 1967</u>		20d INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Office bldg</u>		20f (City or town) (County) (State) <u>Bethesda Mont. Md.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22 DATE SIGNED <u>12/4/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b DATE THEREOF <u>12-12-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>DEC 18 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17146

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CITY CHASE</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 9 mos. 23 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORFOLK</u>		d. STREET ADDRESS <u>6913 FALLISTER RD.</u>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BETHESDA - SILVER SPRING NURSING HOME</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>ROLAND M. BRAINARD</u>		4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-86</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>VICE ADMIRAL - US NAVY - RET.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FREDERICK BRAINARD</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN MUNNICE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES WWII + II</u>		16. SOCIAL SECURITY NO. <u>364 52 9192</u>	
17. INFORMANT <u>PATIENT'S CHART #1</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Controlled explosion</u> DUE TO (b) <u>Gasoline engine explosion</u> DUE TO (c) <u>Gasoline engine explosion</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9:00 AM</u> , 19 <u>66</u> , to <u>12/28</u> , 19 <u>67</u> , that (I) <u>was</u> last saw the deceased alive on <u>12/28</u> , 19 <u>67</u> , and that death occurred at <u>2:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Lennard Gons</u>		22b. DATE SIGNED <u>12/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gons</u>		22d. ADDRESS <u>3641 COLESVILLE RD, SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-2-1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>U.S. ACADEMY</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS A.H. MD.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor Sons Annapolis Md.</u>		25a. REC'D BY REGISTRAR <u>3 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CERTIFICATE OF DEATH

17147

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. in Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY IN TB <u>3 months</u>		d. STREET ADDRESS <u>2916 7th St N.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE BRAUNER</u>		4 DATE OF DEATH Dec 29 19 67	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-18-1892</u>
9. AGE (in years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Amer. Red Cross</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>District of Col.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Brauner</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Hanke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>579-44-5279A</u>	
17. INFORMANT <u>Evelyn Woodward - Neice</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>5810</u> IMMEDIATE CAUSE (a) <u>Cirrhosis of the Liver</u> DUE TO (b) <u>Under</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Under</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Under</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-9</u> , 19 <u>67</u> , to <u>12/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-19</u> 19 <u>67</u> and that death occurred at <u>6 A.M.</u> from causes on the date stated above			
22a. SIGNATURE <u>B. C. Bendlar MD</u> M.D.		22b. DATE SIGNED <u>12/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. C. Bendlar MD</u>		22d. ADDRESS <u>10820 Georgia Ave, S. Sps, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>12/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Lee F.H., 300 4th St NE, Wash., D.C.</u>		25a. REC'D BY REGISTRAR <u>JAN 2 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Judy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17148

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE WASH. D.C. b. COUNTY WASH. D.C.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c LENGTH OF STAY IN 1b 37 MONTHS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WHEATON NURSING HOME		d STREET ADDRESS 4411 17th ST. N.W.	
3 NAME OF DECEASED (Type or print) MARY C. BREEN		4 DATE OF DEATH Month 12 Day 21 Year 1967	
5 SEX F.	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH OCT. 8 - 1872
9a AGE (In years lost birthday) 95 yrs		9b IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Second-TEACHER		10b KIND OF BUSINESS OR INDUSTRY -	
11 BIRTHPLACE (County & State or foreign country) WASHINGTON D.C.		12 CIT. ZEN. OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL BREEN		14. MOTHER'S MAIDEN NAME CATHERINE O'BRIAN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - (If yes give war or dates of serv. ce) -		16 SOCIAL SECURITY NO 577-30-5280-4	
17 INFORMANT Robert J. Bessler-3024 Oliver St. N.W.		Address Wash. D.C.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Arteriosclerosis DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Heart Disease Diabetes Mellitus		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 pm	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Oct. 1964 to Dec. 21, 1967 , that (I) (we) last saw the deceased alive on Dec. 21 1967 , and that death occurred at 9:30 PM , from causes and on the date stated above			
22a. SIGNATURE Bertram F. Schaefer M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Bertram F. Schaefer		22d. ADDRESS 1780 Mass. Ave. N.W. Wash. D.C.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12-23-1967	23c NAME OF CEMETERY OR CREMATORY M. Olivet Cemetery	23d LOCATION (City or town) (County) (State) Washington, D.C.
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wash. D.C.		25a. REC'D BY REGISTRAR DEC 28 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17149

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
c. LENGTH OF STAY IN 1b <i>7 days</i>		d. STREET ADDRESS <i>10300 West Lake St</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edward</i> First Middle Last <i>Brennan</i>		4. DATE OF DEATH <i>Dec 24</i> 19 <i>67</i> Month Day Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-2-1897</i> 9. AGE (In years last birthday) <i>70</i> yrs
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>MADISON, Wisc.</i>		12. CIT. ZEN. OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>THOMAS BRENNAN</i>		14. MOTHER'S MAIDEN NAME <i>KATHRYN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>(WIFE) GERTRUDE BRENNAN SAMEAS #2</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Generalized arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>5 hrs</i> <i>20 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10-7</i> , 19 <i>66</i> , to <i>12-24</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>12-24</i> 19 <i>67</i> and that death occurred at <i>9:23</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Ronald W. Barr</i>		22b. DATE SIGNED <i>12-24-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>RONALD W. BARR</i>		22d. ADDRESS <i>10401 OLD GEORGETOWN RD. BETHESDA, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-28-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>ML. Olivet Cem.</i>	23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>
24. FUNERAL DIRECTOR <i>James E. DeVol-DeVol Funeral Home - Wash. D.C.</i>		25a. REC'D BY REGISTRAR <i>2</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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70-110.

10/11

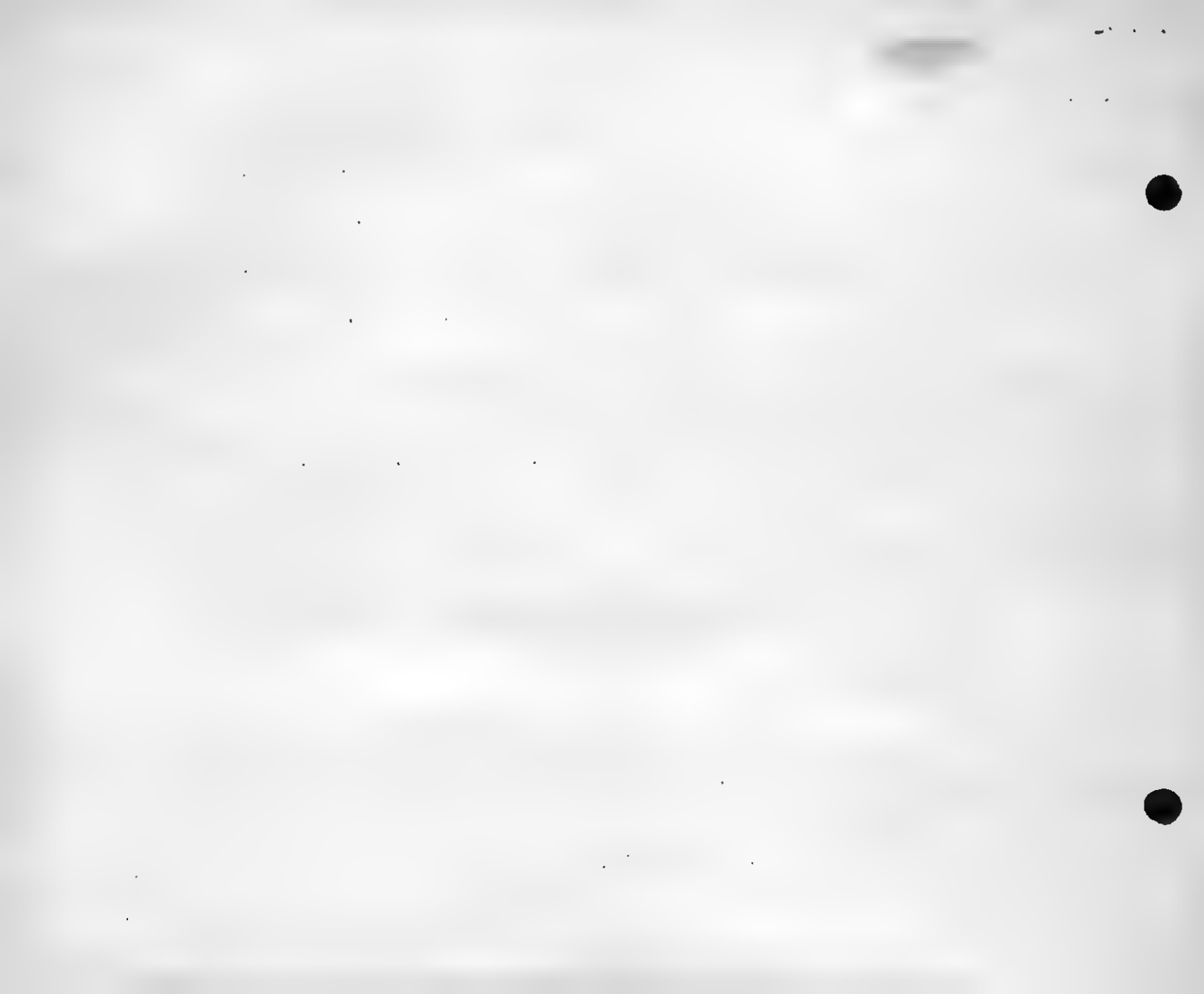
CERTIFICATE OF DEATH

17150

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Patuxent River</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>		d. STREET ADDRESS <u>MEMQ 777A</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Christine Marie BREWER</u>		4 DATE OF DEATH Month Day Year <u>December 9 19 67</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 8, 1967</u>
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Patuxent River, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wiley Phillip Brewer</u>		14. MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO <u>N/A</u>	
17 INFORMANT <u>Mr. Wiley P. Brewer, MEMQ 777A Patuxent/</u>		Address <u>River, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningomyelocele</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from <u>Dec. 8</u> , 19 <u>67</u> , to <u>Dec. 9</u> , 19 <u>67</u> , that (f) (we) last saw the deceased alive on <u>Dec. 9</u> , 19 <u>67</u> , and that death occurred at <u>1245</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Jerry J. Tomasovic</u> M.D.		22b. DATE SIGNED <u>Dec. 12, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jerry J. Tomasovic, M. D.</u>		22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> Address <u>7557 Wisconsin Ave., Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 15 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>W. J. J. J. J.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

17155

17151

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>District of Columbia</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. STREET ADDRESS <u>5249-43rd St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Lillian E. Broches</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 16, 1895</u>	
9. AGE (In years, last birthday) <u>72</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		11. BIRTHPLACE (Country & State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ritter</u>				14. MOTHER'S MAIDEN NAME <u>Dora English</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-18-5921</u>		17. INFORMANT <u>Ralph Broches Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>12/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>67</u> , and that death occurred at <u>9:22</u> PM, from causes and on the date stated above							
22a. SIGNATURE <u>L. J. [Signature]</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. S. BRENNAN</u>				22d. ADDRESS <u>1200 [Address]</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-18-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Maryland</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home-300 14th St. NE Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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7156

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17152

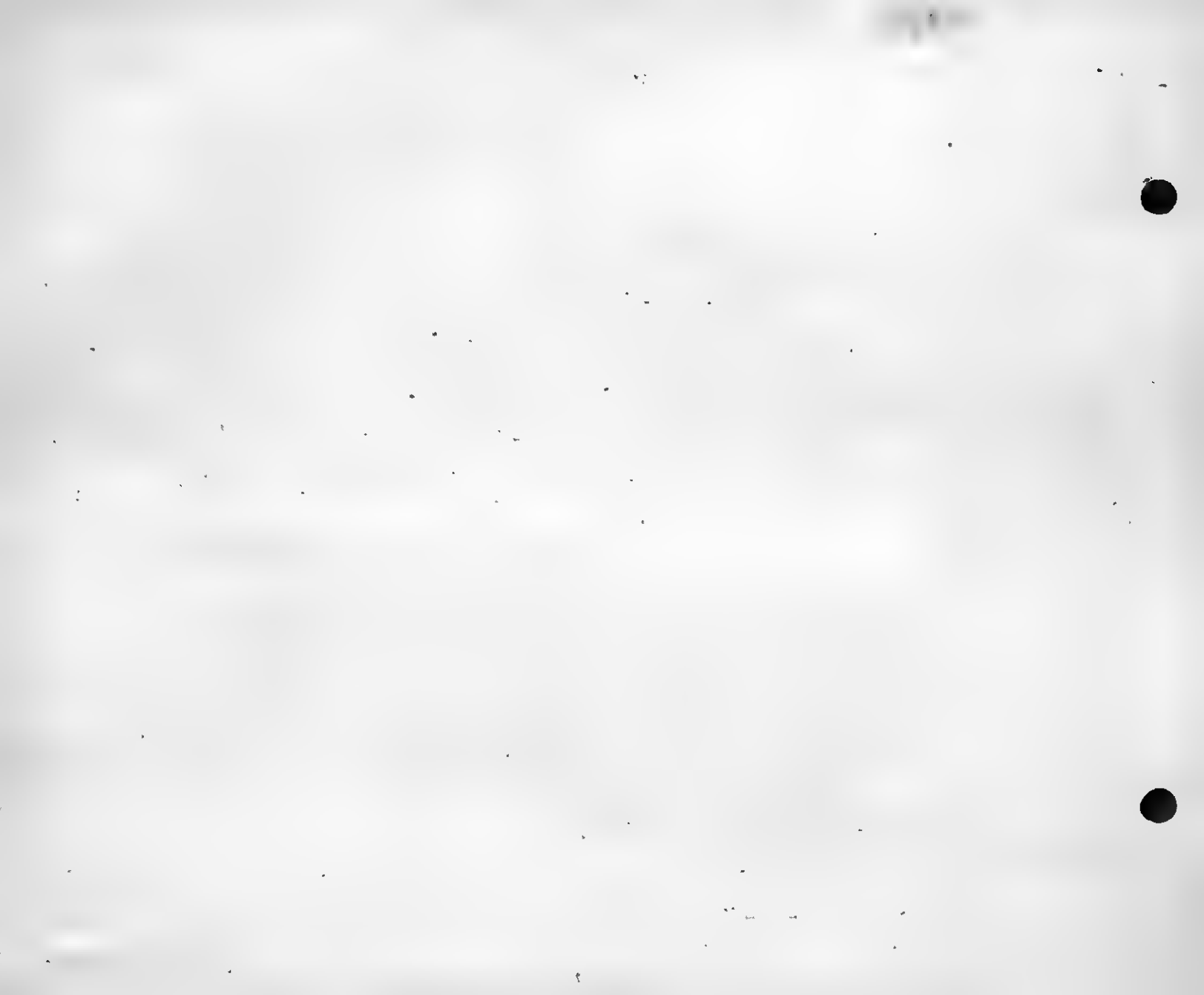
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u>	
c. LENGTH OF STAY IN 1b <u>3 years</u>		d. STREET ADDRESS <u>10715 Meadow Hill Road</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>10715 Meadow Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHESTER</u> Middle <u>John</u> Last <u>BROOK'S</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 31, 1907</u>
9. AGE (In years lost birthday) yrs. <u>60</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>3</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>	
11 BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ira Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Annie Deel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>578-38-0382</u>	
17 INFORMANT <u>Mrs. Leda L. St. Lawrence</u>		Address <u>10715 Meadow Hill Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u>			
162x DUE TO <u>CARCINOMA OF LUNG</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UNKNOWN</u>			
(c) <u>UNKNOWN</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>MARCH 24, 1966</u> , to <u>DEC 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>DEC 17, 1967</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur S. Bressler</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED <u>DEC 18, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur S. Bressler</u>		22d. ADDRESS <u>10881 Lockwood Br. Silver Spring, Md.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Inter-burial</u>		23b. DATE THEREOF <u>Dec. 22, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sayville, New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Humphrey, Jr.</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Thomas J. ...</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
17153													
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR		
Barkara							Krosart		Month Day Year		27 27 67		
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
Fe		Wh.		12/29/29			87 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Germany			USA					Montgomery Co.		Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Cherry Chase Nursing & Conv. Center										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md			Montgomery			Bethesda				6505 Bradley Blvd			
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
Unknown									Kunigunda			Meier	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT							
No			none			Mrs Richard Livingston Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Cerebrovascular Accident										1 hour			
DUE TO, OR AS A CONSEQUENCE OF (b)										3 yrs.			
Generalized arteriosclerosis													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
None													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from June, 1962, to Dec 27, 1967, that (I) (we) last saw the deceased alive on Dec 26, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)							
Sanford J. Randall, MD			12-27-67			S. J. RANDALL							
22e. ADDRESS			22f. ADDRESS										
			Boonville Tenn. N.W. D.C.										
23a. BURIAL, CREMATION, REMOVAL (Type)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			12-30-67		United German & French			Cheektowaga New York					
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Robert A Pumphrey			DATE JAN 5 1968			j Charles J. J. J.							
7557 Wisconsin Ave													
Bethesda, Md													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN lb One hour		d. STREET ADDRESS 3600 Glen Eagles Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTHA L. BROWN		4. DATE OF DEATH Month 12 Day 26 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-29-75
9. AGE (In years lost b rthday) 92 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife retired	
11. BIRTHPLACE (County & State, or foreign country) Leesburgh Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Ryon		14. MOTHER'S MAIDEN NAME Annie Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578-52-0236	
17. INFORMANT Paul B. Long		Address 4905 Melinda Ct., Rockville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, acute DUE TO (b) Occlusion Rt. coronary artery DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 67 , 19, to Dec 26, 1967 , that (I) (we) last saw the deceased alive on 12/26 , 19 67 , and that death occurred at 12/26 , 19 67 , from causes and on the date stated above.			
22a. SIGNATURE Richard A. Yates M.D.		22b. DATE SIGNED 12/26/67	
22c. PHYSICIAN'S NAME (Type) Richard A. Yates		22d. ADDRESS Old Baltimore St. Olney, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
25a. RECD BY REGISTRAR Jan 4 1968		25b. REGISTRAR'S SIGNATURE John J. Judge	

Cleared with Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

17159				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17155							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND								2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>				c. LENGTH OF STAY IN 1b <u>15 Years</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8812 Maywood Ave.</u>				d. STREET ADDRESS <u>8812 Maywood Ave.</u>				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Mary</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1967</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>9-8-05</u>		9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR Months Days Hours Min					
10a. USUA. OCCUPAT ON (Give kind of work done during most of work month, even if retired) <u>Housewife & Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>University</u>				11. BIRTH PLACE (County & State, or foreign country) <u>New Jersey</u>							
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Patrick Reynolds</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Dunnigan</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO				17. INFORMANT Wm. A. Brown Husband #2							
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Coronary Artery Thrombosis</u> 4001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cirrhosis</u> (c) <u>4001</u> DUE TO DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>7-15</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cirrhosis</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (This hospital) attended the deceased from <u>11/27/67</u> to <u>12/2/67</u> , that (I) (we) last saw the deceased alive on <u>11/27/67</u> , and that death occurred at <u>4:15</u> M, from causes and on the date stated above															
22a. SIGNATURE <u>Edward G. Ford</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED <u>12/2/67</u>							
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Newark, N.J.</u>									
24. FUNERAL DIRECTOR <u>Robert A. DeVol</u>				25a. REGISTERAR <u>DEC 5 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

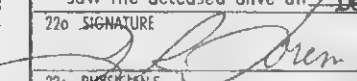
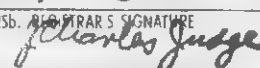
7160

17156

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN It <u>19 Nov 15 Nov</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Barthersburg</u> d. STREET ADDRESS <u>Rt 1 Box 208 Emory Grove Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Eric</u> <u>Lamont</u> <u>Brown</u> First Middle Last		4. DATE OF DEATH <u>Dec 5</u> <u>19 1967</u> Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 4, 1967</u>	
9. AGE (in years last birthday) <u>19</u> <u>15</u> Months Days Hours M n.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>montgomery Co., Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Brenda Jean Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(yes) give year or dates of service</u>		16. SOCIAL SECURITY NO. <u>Birth Certificate</u>	
17. INFORMANT <u>Birth Certificate</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 4</u> <u>1967</u> to <u>Dec 5</u> <u>1967</u> that (I) (we) last saw the deceased alive on <u>Dec 5</u> <u>1967</u> and that death occurred at <u>9:10 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James A Davis Jr.</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A DAVIS JR.</u>		22d. ADDRESS <u>8218 Wisconsin Ave, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/7/67</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		23d. LOCATION (City, town or county) (State) <u>Bethesda-Montg. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Amelia C. Carter, Administrator (EA)</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE	

CERTIFICATE OF DEATH

17157

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Falls Church	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN it 52 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 3205 Olds Drive	
3. NAME OF DECEASED (Type or print) Kermit King BROWN		4. DATE OF DEATH Month December Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jul. 12, 1918
9. AGE (in years last birthday) yrs 49		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Shelby		14. MOTHER'S MAIDEN NAME Alice Marie Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1941-1944		16. SOCIAL SECURITY NO.	
17. INFORMANT Falls Church, Va. Address Mrs. Elizabeth C. Brown, 3205 Olds Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma with widespread lymphatic metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 7, 1967 , to Dec. 29, 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 29, 1967 , and that death occurred at 935AM , from causes and on the date stated above			
22a. SIGNATURE 		22b. DATE SIGNED Dec. 30, 1967	
22c. PHYSICIAN'S NAME (Type) D. R. FOREMAN, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR C. M. Francis ADDRESS Murphy Funeral Home, 3524 Columbia Pike Arlington, Virginia		25a. BY REGISTRAR JA 4 1968 DATE	
		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17162

17158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Charles by Med Examiner of Monty County - Ch. Deaf

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL, DR. INSTITUTION (If not in hospital give street address) <u>7344 Carroll Avenue</u>				d. STREET ADDRESS <u>7344 Carroll Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Mosquear</u> First <u>S.</u> Middle <u>Brown</u> Last				4. DATE OF DEATH <u>12/30/67</u> Month <u>12</u> Day <u>30</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept 15 1879</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Keppin West Va.</u>		12. CIT. ZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John W. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Finnell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>57701 9853</u>		17. INFORMANT <u>Mrs. Lelia K. Montgomery (same as #2)</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aden Carcinoma of Prostate with Metastases</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u> </u> (c) <u>Ch. Deg. Degeneration - occ. Decomp</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg. etc.)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> , 1961, to <u>12/30</u> , 1967, that (I) (we) last saw the deceased alive on <u>12/21</u> , 1967, and that death occurred at <u>9:15 PM</u> , from causes and on the date stated above				22a. SIGNATURE <u>H. T. Morse</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>H. T. Morse M.D.</u>				22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 2, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Adelphi Md</u>	
24. FUNERAL DIRECTOR <u>Takoma Funeral Home J. G. Walter</u> ADDRESS <u>254 Carroll St NW</u>				25a. REC'D BY REGISTRAR <u>JAN 4 1968</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7163

17159

1 PLACE OF DEATH a. COUNTY <u>SILVER SPRING</u> <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>		d. STREET ADDRESS <u>8407 11th AVE.</u>	
3 NAME OF DECEASED (Type or print) <u>LYDIA</u> First <u>M.</u> Middle <u>BRYANT</u> Last		4 DATE OF DEATH Month <u>DECEMBER</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/1/88</u>
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jonathan Bryant</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Weaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Charles W. Bryant</u>		Address <u>8407 11th Ave S11 Sp</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforated Peptic ulcer</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Diabetes Mellitus</u> DUE TO <u>late onset</u> (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>few weeks</u> <u>few days</u> <u>1 year +</u> <u>Years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>Dec. 6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 6</u> , 19 <u>67</u> , and that death occurred at <u>4:30 P.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Hugo G. Graziani</u> M.D.		22b. DATE SIGNED <u>12/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI, M.D.</u>		22d. ADDRESS <u>10101 GEORGIA AVE S.S., Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12-10-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Providence Meth. Church</u>	23d. LOCATION (City or Town) (County) (State) <u>Chiltons Virginia</u>
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm</u> <u>4308 Suitland Road Suitland Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

17150

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE New York b. COUNTY 6		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 50 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Far Rockaway	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital			d. STREET ADDRESS 6983 Hillmyer Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Jessie (none) BUCHANON			4. DATE OF DEATH Month December Day 3 Year 19 67		
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 1925	9. AGE (In years last birthday) 42 yrs	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Riverview, Alabama	
13. FATHER'S NAME George Buchanan			14. MOTHER'S MAIDEN NAME Blannie Mae Wells		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) Yes 1950-1967		16. SOCIAL SECURITY NO. 423 18 4595		17. INFORMANT Far Rockaway, N.Y. Navy Records Mrs. Marion V. Buchanan, 6983 Hillmyer Ave.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic carcinoma DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (A) (this hospital) attended the deceased from Oct. 18 , 19 67 , to Dec. 3 , 19 67 , that (B) (we) last saw the deceased alive on Dec. 3 , 19 67 , and that death occurred at 5:43 PM , from causes and on the date stated above.					
22a. SIGNATURE Mitchell Mills			22b. DATE SIGNED Dec. 5, 1967		
22c. PHYSICIAN'S NAME (Type) Mitchell Mills, M. D.			22d. ADDRESS Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 12-7-67	23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	23d. LOCATION (City or Town) (County) (State) Riverview Alabama		
24. FUNERAL DIRECTOR Ward-Funeral-Home Fairfax, Alabama-Funeral Home, Falls Church			25a. REC'D BY REGISTRAR DEC 11 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

17161

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>9316 Piney Br. Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Jan & Hosp</u>		d. STREET ADDRESS <u>Silver Springs</u>	
3. NAME OF DECEASED (Type or print) <u>Lena</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1896 Sept 16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Europe-Lithuania</u>	
11 BIRTHPLACE (County & State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Chaim Kobre</u>		14 MOTHER'S MAIDEN NAME <u>Rachel Gentis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>578-48-6029</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic CARCINOMA</u> DUE TO (b) <u>Carcinoma of Colon</u> DUE TO (c) <u>lost</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE MDW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>12-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-25</u> , 19 <u>67</u> , and that death occurred at <u>11:55 A.M.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Gilbert B. Cushman</u>		22b. DATE SIGNED <u>12-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gilbert B. Cushman</u>		22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hyattsville, Maryland</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u> <u>3501 14th St. NW, Washington, D.C. 20010</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 396

12-29-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7166

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17162

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c LENGTH OF STAY IN 1b 20 YRS			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt 2 Good Hope Rd				d. STREET ADDRESS Rt 2, Good Hope Rd			
3 NAME OF DECEASED (Type or print) TENCIE (NMN) BURTON				4 DATE OF DEATH Month 12 - Day 12 Year 1967			
5 SEX FEMALE		6 COLOR OR RACE NEGRO		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Sept. 24, 1908 59 yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) NORTH CAROLINA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME JOHN THORP				14 MOTHER'S MAIDEN NAME Unk.			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO		17 INFORMANT DAUGHTER Address SAME	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute coronary insufficiency with 4201 DUE TO severe cardiomegaly and severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO intracranial atherosclerosis (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Dec. 12, 1967			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)	
BURIAL		Dec. 16, 1967		Good Hope Cemetery		Silver Spring Montg. Md.	
24 FUNERAL DIRECTOR Robert L. Snowden				25a REC'D BY REG-STRAR Rockville, Md.			
				25b REGISTRAR'S SIGNATURE DEC 21 1967			

1. The first part of the

document is a list of

the names of the

persons who have been

in

the second part of the

document is a list of

the names of the

persons who have been

in

MEDICAL CERTIFICATION

VR A15ME (5)
6M 1/67 1

1. PLACE OF BIRTH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>DOA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) <i>Washington San-Hosp</i>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <i>Adelphi</i>	
4. NAME OF DECEASED (Type or print) <i>Raymond Ignatius Cady</i>		4. STREET ADDRESS <i>2409 Lyndon St</i>	
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-1-23</i>	
9. AGE (In years lost birthday) <i>44</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Bernard Cady</i>		14. MOTHER'S MAIDEN NAME <i>Elsie Anderson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>YES II</i>		16. SOCIAL SECURITY NO. <i>Wife</i>	
17. INFORMANT <i>Wife</i>		18. ADDRESS	
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Heart Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>DEC. 3, 1967</i>	
ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 6, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md</i>	
24. FUNERAL DIRECTOR <i>Takoma Funeral Home</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>DEC 7 1967</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

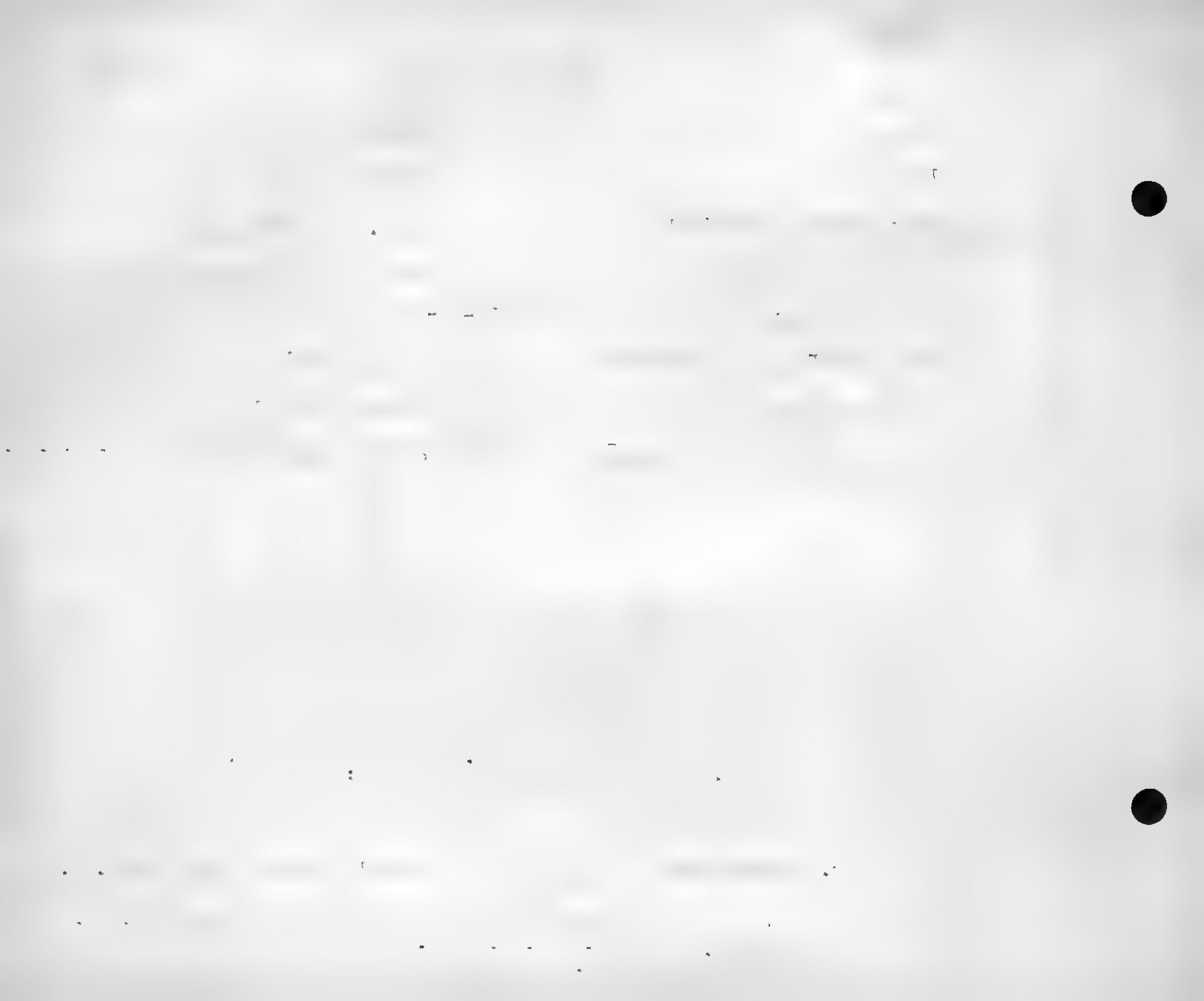
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17164

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 15811 Mt. Everest Lane	
3 NAME OF DECEASED (Type or print) Giosue Joe Canova		4 DATE OF DEATH December 9 19 67		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-17-01	9. AGE (in years lost birthday) 65 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Baker		10b. KIND OF BUSINESS OR INDUSTRY Federated Bakery		11. BIRTHPLACE (County & State, or foreign country) Switzerland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Giosue Canova		14. MOTHER'S MAIDEN NAME Catherine Trippel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 577-09-1804 Not Known		17. INFORMANT Frank Greene Montgomery General Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO (b) Adenocarcinoma of Prostate DUE TO (c) last		INTERVAL BETWEEN ONSET AND DEATH 2 yrs		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 4 , 19 67 , to Dec. 9 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 9 , 19 67 , and that death occurred at 6:15 A M, from causes and on the date stated above.					
22a. SIGNATURE Dr. Charles Ligon		22b. DATE SIGNED 12/10/67		22c. PHYSICIAN'S NAME (Type) Dr. Charles Ligon	
22d. ADDRESS Medical Center, Sandy Spring, Md.		22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec. 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	
23d. LOCATION (City or Town) Prince Georges Co. Md.		23e. ADDRESS 8434 Ga. Ave. S.S. Md.		23f. RET'D BY REG STRAR C. Glen Carter	
23g. FUNERAL DIRECTOR James J. Appach, Inc.		23h. REG STRAR'S SIGNATURE Charles Judge		23i. DATE DEC 13 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
17169									
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>11601 Idlewood Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Hugh</u> Middle <u>Dorsey</u> Last <u>Carmichael</u>					4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1967</u>				
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Jan. 1, 1914</u>		9. AGE (in years last birthday) <u>53</u> yrs	IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u> Hours <u>67</u> Min		IF UNDER 24 HRS Months <u>16</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farrier</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Doctors Hospital</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Hugh B. Carmichael</u>					14. MOTHER'S MAIDEN NAME <u>Effie Odum</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO <u>254-18-7907</u>		17. INFORMANT <u>Lucille Carmichael</u> <u>11601 Idlewood Road</u> <u>Silver Spring, Maryland</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <u>one day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 15</u> , 19 <u>67</u> , to <u>Dec 16</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Dec 15</u> 19 <u>67</u> , and that death occurred at <u>1:40 AM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED <u>12/16/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. EIG.</u>					22d. ADDRESS <u>8641 Columbia Rd Silver Spring, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Kochville, Maryland</u>		
24. FUNERAL DIRECTOR <u>James S. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		
25c. ADDRESS <u>8474 Georgia Avenue Silver Spring, Maryland</u>				DATE <u>DEC 20 1967</u>					

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17166

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>1200 Claggett St.</u>	
3. NAME OF DECEASED (Type or print) <u>Edward A Carter</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/1895</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Carter</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mathews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-013774A</u>	
17. INFORMANT <u>Myrtle A. Mills-daughter-same item + 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Ca of Colon</u> 1538 DUE TO (b) <u>6 mo.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>now</u> , 19 <u>67</u> , to <u>12-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-25</u> 19 <u>67</u> , and that death occurred at <u>11:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. James T. McCarrick</u> M.D.		22b. DATE SIGNED <u>12/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. James T. McCarrick</u>		22d. ADDRESS <u>5218 Wisconsin Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, or other disposition <u>Burial</u>	23b. DATE THEREOF <u>12/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Derwood</u>	23d. LOCATION (City or town) (County) (State) <u>Derwood, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyron Wheeler Funeral Home</u>		25. REC'D BY REGISTRAR <u>Rockville, Maryland</u> DATE <u>JAN 2 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17167

7171

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda, Silver Spring University</u>		d. STREET ADDRESS <u>1709 Caplinger Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>MARY Eileen CARTER</u>		4. DATE OF DEATH <u>Dec. 10 1967</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carter Const. Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>UTAH</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dilbert Nebeker</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		17. INFORMANT <u>James E. Carter 11709 Caplinger Rd. NEKSIA & RECORDS Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Cerebral Metastasis</u> DUE TO (c) <u>Carcinoma Breast</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>67</u> to <u>12-10</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12-10</u> 19 <u>67</u> , and that death occurred at <u>2:30 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert Kramer</u> M.D.		22b. DATE SIGNED <u>12/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT KRAMER</u>		22d. ADDRESS <u>8484 16th St. SS Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Dec. 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>Clark E. Wilson</u> ADDRESS <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 13 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

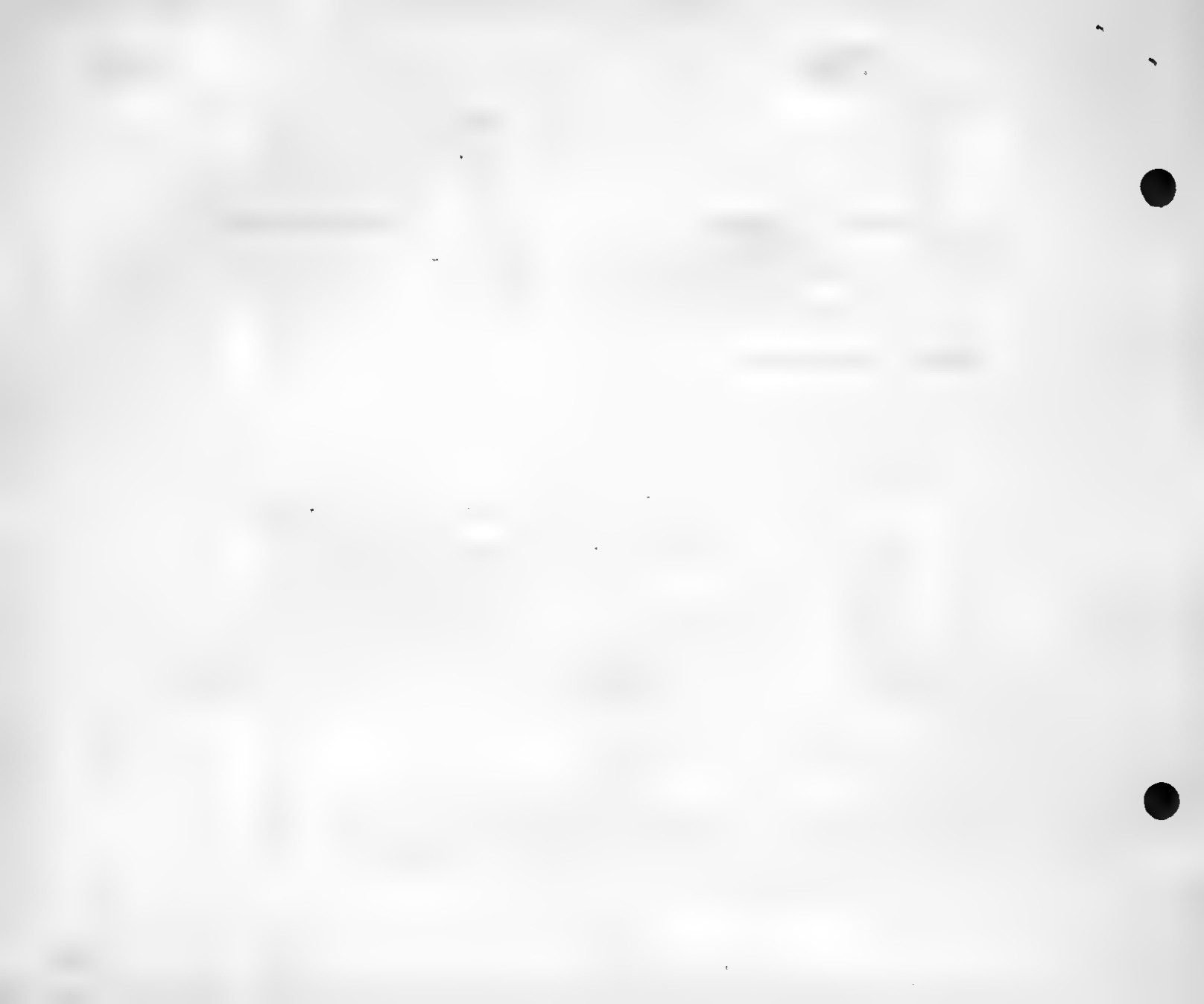
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17168

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY in 1b <u>15 days</u>		d. STREET ADDRESS <u>8313 Garland Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lorence R. Castle</u>		4. DATE OF DEATH <u>Dec. 27 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/1917</u>
9. AGE (In years, last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>P. Z. CASTLE</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA SELLERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hosp. RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction, old & recent, anterior left ventricle and interventricular septum</u>			
(b) <u>marked coronary arteriosclerosis</u>			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Right Hip.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fallen in nursing home, causing fracture of Rt hip</u>	
20c. TIME OF INJURY Month, Day, Year <u>Dec 12/25 1967</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>nursing home</u>	
20e. INJURY OCCURRED While at work <input type="checkbox"/> hot While at work <input checked="" type="checkbox"/>		20f. (City or town) (County) (State) <u>Kensington Montgomery Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		22. DATE SIGNED <u>12/28/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town or county) <u>BETHESDA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-1-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glover Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Glover Gap Wetzel W. Va.</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, 7557 Wisconsin Ave.</u>		25. REC'D BY REGISTRAR <u>Charles J. J...</u> DATE <u>JAN 5 1968</u>	



CERTIFICATE OF DEATH

17169

17173

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, and 6 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>71 Wash. San & Hosp.</i>		d. STREET ADDRESS <i>7313 Flower Ave.</i>	
3 NAME OF DECEASED (Type or print) <i>Bertha E. Chapin</i>		4 DATE OF DEATH <i>December 26 1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 8 - 1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>	9. AGE (in years last birthday) <i>90</i> yrs.
11. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Dwight Anderson</i>		14. MOTHER'S MAIDEN NAME <i>Clarassia Rockwell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>577-07-2013</i>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hypertensive Pneumonia</i> DUE TO <i>Chl. Wrenner</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cent. Cystitis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>12/18, 1967</i> to <i>12/26, 1967</i> , that (I) (we) last saw the deceased alive on <i>12/26, 1967</i> , and that death occurred at <i>PM</i> , from causes and on the date stated above			
22a. SIGNATURE <i>H. T. Morse</i>		22b. DATE SIGNED <i>12/26/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>H. T. Morse</i>		22d. ADDRESS <i>7030 Carroll Rd Takoma Park Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>Dec 28, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Agnes Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co. Md.</i>
24. FUNERAL DIRECTOR'S NAME (Type) <i>Barner E. Humphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>Charles Jones</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>JAN 2 1968</i>	

CERTIFICATE OF DEATH

171770

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE South Carolina b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myrtle Beach		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 1406 North Chester St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Christopher Scott CHASTAIN				4. DATE OF DEATH Month December Day 13 Year 19 67			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1967	9. AGE (In years lost birthday) yrs 28		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 28 Days 28 Hours 28 Min.	
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Myrtle Beach, S. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dwight H. Chastain				14. MOTHER'S MAIDEN NAME Tonda Loy Fernandez			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Chester St. Address Myrtle Beach, SC SGT Dwight H. Chastain, USAF, 1406 North			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 7593 IMMEDIATE CAUSE (a) MULTIPLE CONGENITAL DEFECTS DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 6 , 1967, to Dec. 13 , 1967, that (X) (we) last saw the deceased alive on Dec. 13 , 1967, and that death occurred at 240A M, from causes on and on the date stated above.							
22a. SIGNATURE Gene P. Swartz				22b. DATE SIGNED Dec. 13, 1967		22c. PHYSICIAN'S NAME (Type) GENE P. SWARTZ MD.	
22d. ADDRESS Naval Hospital, Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-16-67		23c. NAME OF CEMETERY OR CREMATORY Jacksonville Mem. Gardens, Clay County, Fla.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland				25a. REC'D BY REGISTRAR DEC 18 1967		25b. REGISTRAR'S SIGNATURE William J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4 and 5, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17175

17171

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince Georges</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN lb <u>159 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. STREET ADDRESS <u>5564 Maxwell Drive</u>	
3 NAME OF DECEASED (Type or print) First <u>Ireda</u> Middle <u>June</u> Last <u>Christiansen</u>		4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>19 67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19, 1942</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>California</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Harris</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle Blodgett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Not available</u>	
17. INFORMANT <u>The Medical Records</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Multiple pulmonary emboli</u> DUE TO (c) <u>Acute myelogenous leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>1 month</u> <u>6 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic failure, probable drug toxicity (weeks)</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>5</u>
21. I certify that (1) (this hospital) attended the deceased from <u>June 29</u> , 19 <u>67</u> , to <u>December</u> , 19 <u>67</u> , that (4) (we) last saw the deceased alive on <u>December 5</u> , 19 <u>67</u> , and that death occurred at <u>6:03 M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>David L. Lilien</u>		22b. DATE SIGNED <u>5 December 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>David L. Lilien, MD</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Memorial Pk. Cemetery, Tacoma, Washington</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17176

17172

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>5209 Wilson Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Christison</u> Middle Last		4. DATE OF DEATH <u>12-29</u> Month Day Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-57</u> 10
9. AGE (In years last birthday) <u>10</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Christison</u>		14. MOTHER'S M maiden name <u>Katherine Talbot</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>MOTHER-Katherine -</u>	
17. INFORMANT <u>MOTHER-Katherine -</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>7294</u> IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Drowning -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>3 min?</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>Found at bottom of YMCA Swimming Pool -</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year <u>11:30 am 12/29/67</u>		20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>Swimming Pool</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>Bethesda</u>		20f. (City or town) (County) (State) <u>Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspect an <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S Ball</u> M.D.		22. DATE SIGNED <u>12/29/67</u>	
EXAMINER'S NAME (Type) <u>F. Gasch's Sons</u>		23a. BURLIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	
23b. DATE THEREOF <u>12/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. Lincoln Cemetery</u>	
23d. LOCATION (City or town) (County) (State) <u>Colmar Manor PG Md</u>		24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md</u>	
25a. REC'D BY REGISTRAR <u>JAN 4 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

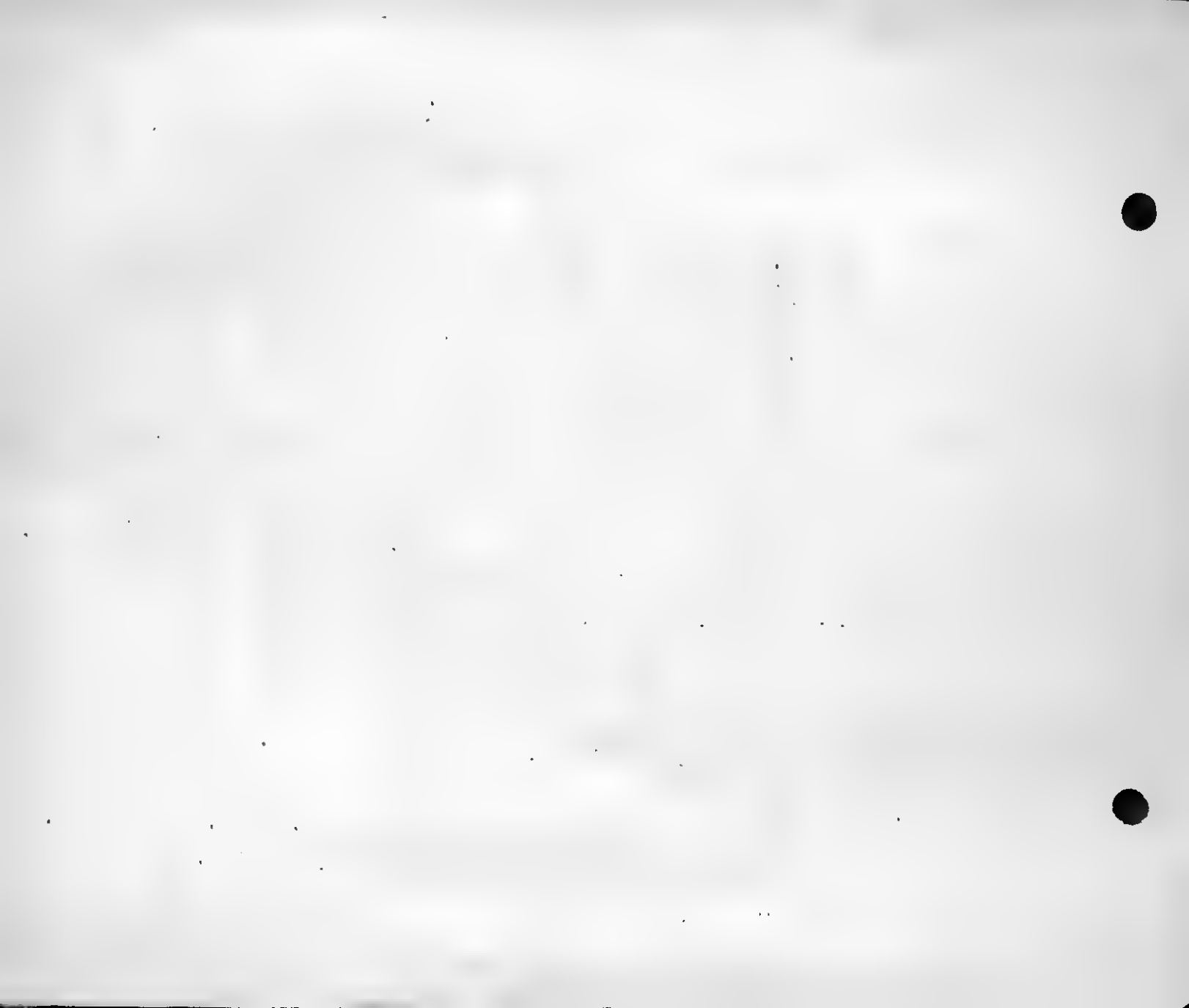
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Boyds</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary L Clagett</u>		4. DATE OF DEATH Month Day Year <u>Dec. 19 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21 - 1897</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward O. Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Ida Mae Cowell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-44-8161</u>	
17. INFORMANT <u>Miss Kathleen Clagett</u> Address <u>Pasadena Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>UREMIA - Chronic</u> DUE TO <u>Pyonephrosis - Pyonephrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerosis -</u> (b) <u>Arteriosclerosis -</u> (c) <u>Arteriosclerosis -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. " 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 3, 1967</u> to <u>Dec 19, 67</u> , that I last saw the deceased alive on <u>Dec. 16, 1967</u> , and that death occurred at <u>6 pm</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.		ADDRESS (Street, city or town, state) <u>105 Russell Ave 12-20-67</u>	
PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>		Gaither'sburg, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/21/67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>	22d. LOCATION (City, town or county) (State) <u>Rockville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u>		ADDRESS <u>Barnesville, Md</u>	
24a. REC'D BY REGISTRAR <u>DEC 26 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

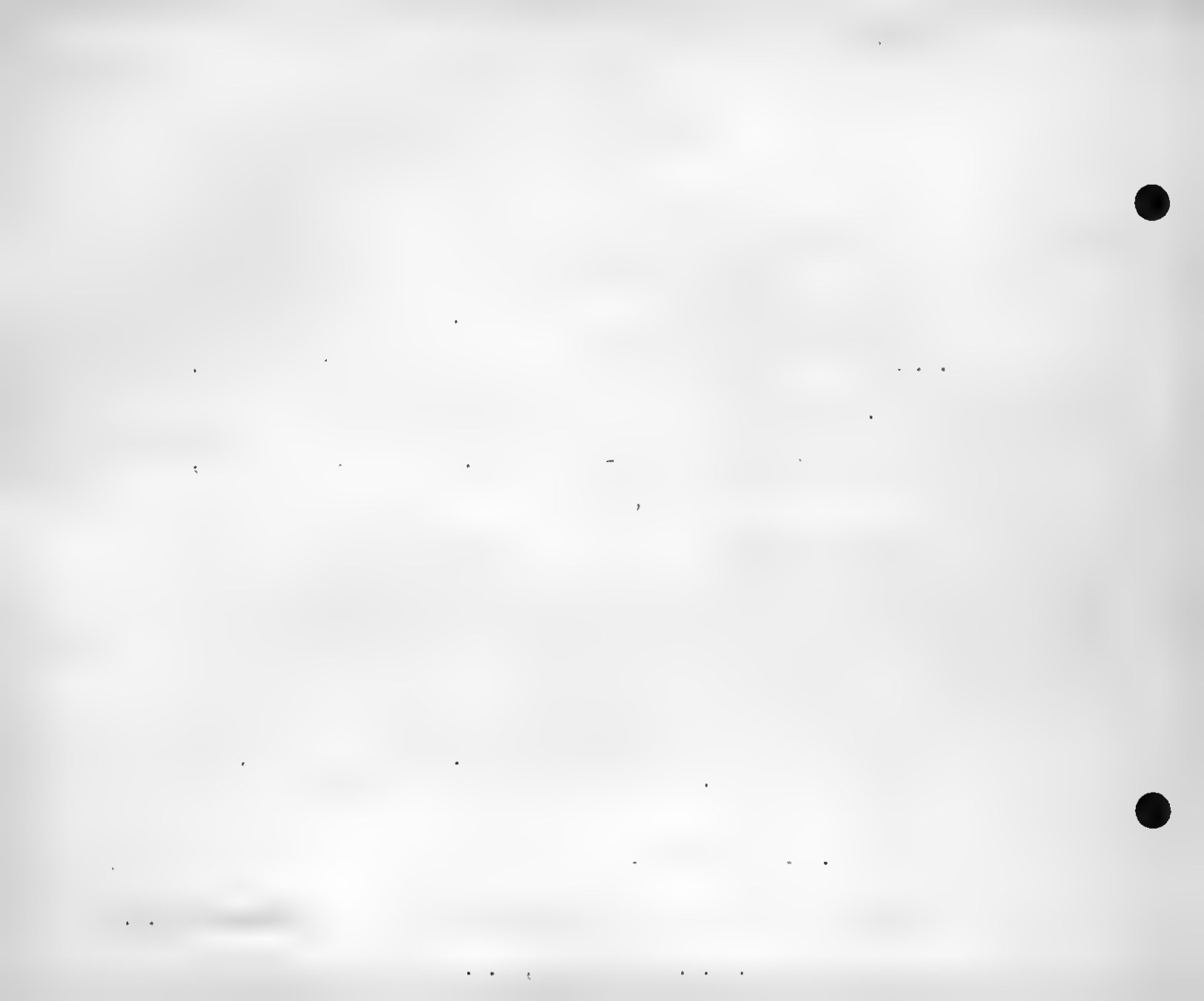
17174

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanatorium</u>		d. STREET ADDRESS <u>32700 Hardy Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Bulah</u> Middle <u>Anna</u> Last <u>Clarke</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16 1880</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James F. Hardy</u>		14. MOTHER'S MAIDEN NAME <u>May E. Sheehy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-52-8143</u>	
17. INFORMANT <u>John H. Hardy</u>		Address <u>300 Hilton Avenue</u> <u>Takoma Park, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/1/67</u> , 19 <u>67</u> , to <u>12/19/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/18/67</u> , 19 <u>67</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Patrick C. Jameson</u>		22b. DATE SIGNED <u>12/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Patrick C. Jameson</u>		22d. ADDRESS <u>11718 Georgia Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 22, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>John E. Pharr</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John E. Pharr</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH						
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						
CERTIFICATE OF DEATH						
17179						
17175						
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>			d. STREET ADDRESS <u>10401 Grosvenor Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cyrus</u> Middle <u>Churchill</u> Last <u>Cole</u>			4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1913</u>	9. AGE (in years lost, birthday) <u>54</u> yrs	IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Manilla, Phillipine Is.</u>		
13. FATHER'S NAME <u>Cyrus W. Cole</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>1935-1965</u>		17. INFORMANT <u>Mrs. Marjorie Garland Cole</u>	
			Address <u>10401 Grosvenor Pl.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 12</u> , 19 <u>67</u> , to <u>Dec. 7</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 7</u> , 19 <u>67</u> , and that death occurred at <u>0515</u> M, from causes and on the date stated above						
22a. SIGNATURE <u>JR Fletcher</u>			22b. DATE SIGNED <u>8 Dec 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. R. FLETCHER MD.</u>			22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Dec. 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or town) _____ (County) _____ (State) _____ <u>Suitland, Maryland</u>		
24. FUNERAL DIRECTOR <u>Joseph Gawlers Sons</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
5133 Wisconsin Ave. N.W., Washington, D.C.			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
			DATE <u>DEC 15 1967</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

<div>17130</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>17176</div>											
1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>						c LENGTH OF STAY IN 1b <u>Rockville</u>					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>338 - W. Edmonston Tr.</u>						d STREET ADDRESS <u>338 - W. Edmonston Tr.</u>					
3 NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Marie</u> Last <u>Collier</u>						4 DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1967</u>					
5 SEX <u>Female</u>		6 COLOR OR RACE <u>white</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>5/5/18</u>		9 AGE (In years last birthday) <u>49</u> yrs		IF UNDER 1 YEAR Months <u>16</u> Days <u>14</u> Hours <u>16</u> Min <u>47</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary-Morris Decorators</u>						10b KIND OF BUSINESS OR INDUSTRY			11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		
13 FATHER'S NAME <u>John W. Cross</u>						14 MOTHER'S MAIDEN NAME <u>Sarah M. King</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO		17 INFORMANT <u>Wilburn P. Collier, Jr. same as #2</u>				Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia Aspiration Gastric Contents</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fatty Metamorphosis of Liver Acute</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>2 h. 7</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>John G. Ball</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/17/67</u>					
						Address (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b DATE THEREOF <u>12/20/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Manassas Cemetery</u>				23d LOCATION (City or Town) (County) (State) <u>Manassas, Va.</u>	
24 FUNERAL DIRECTOR <u>The S.H. Hines Company</u> <u>2901 14th St. N.W. Washington, D.C.</u>						25a REC'D BY REG. STRAR DATE <u>DEC 20 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY COUNTY				MARYLAND				MONTGOMERY COUNTY				MARYLAND			
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland				b. COUNTY Howard							
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b DOA				c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Ellicott City							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS Rt. 4				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last James Edwin Combs				4. DATE OF DEATH Month Day Year 12 30 19 67											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06/18/11		9. AGE (In years last birthday) 56 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs				10b. KIND OF BUSINESS OR INDUSTRY West Virginia				11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Combs				14. MOTHER'S MAIDEN NAME Rebecca Cain											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO 236-14-6877				17. INFORMANT Harold Combs				2208 PLEASANT VIEW CANTONVILLE 28, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency due to DUE TO Conditions, (only which gave rise to immediate cause (a), stating the underlying cause last.) (b) Arteriosclerotic heart disease DUE TO (c) Hypertension; Chronic Ethylism												INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension; Chronic Ethylism												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED DEC. 31, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				ADDRESS Ellicott City, Md.				23a. BURA CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 1-4-68			
23c. NAME OF CEMETERY OR CREMATORY Good Shepherd				23d. LOCATION (City or Town) (County) (State) Ellicott City Howard Md				25a. REC'D BY REGISTRAR DATE JAN 3 1968				25b. REGISTRAR'S SIGNATURE Charles Judge			
24. FUNERAL DIRECTION Higginbotham-Slack				ADDRESS Ellicott City, Md.											

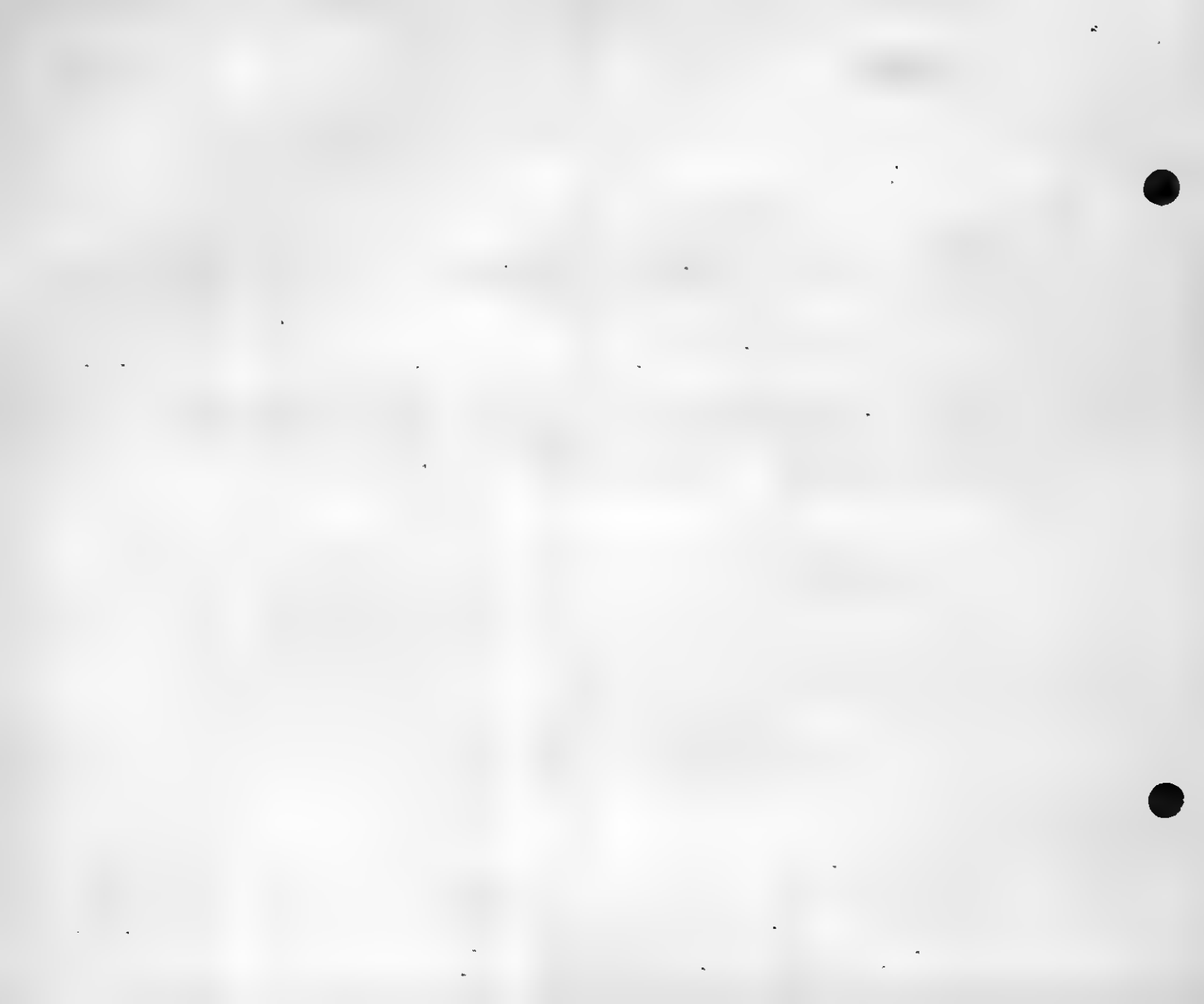
CERTIFICATE OF DEATH

17178

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>19 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10414 Lorain Avenue</u>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10414 Lorain Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Jack H. Connelly</u>		4 DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 12, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Procurement</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>	9 AGE (In years last birthday) <u>73</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John H. Connelly</u>		14. MOTHER'S MAIDEN NAME <u>Cora M. Bickelhaupt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>082-01-0094</u>	
17 INFORMANT <u>A Greta L. Connelly</u>		Address <u>10414 Lorain Avenue Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myelogenous Leukemia</u> DUE TO <u>1961</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>last.</u> (b) <u>DUE TO</u> (c) <u>DUE TO</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2.4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Artery Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/25</u> , 19 <u>65</u> , to <u>12/7</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12/6</u> , 19 <u>67</u> , and that death occurred at <u>3A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>G. Leonard Gold</u> M.D.		22b. DATE SIGNED <u>12/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold</u>		22d. ADDRESS <u>9801 Georgia Avenue, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Dec. 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>Thomas E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>DEC 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James E. Humphrey</u>		25c. REGISTRAR'S SIGNATURE <u>James E. Humphrey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete and correct in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

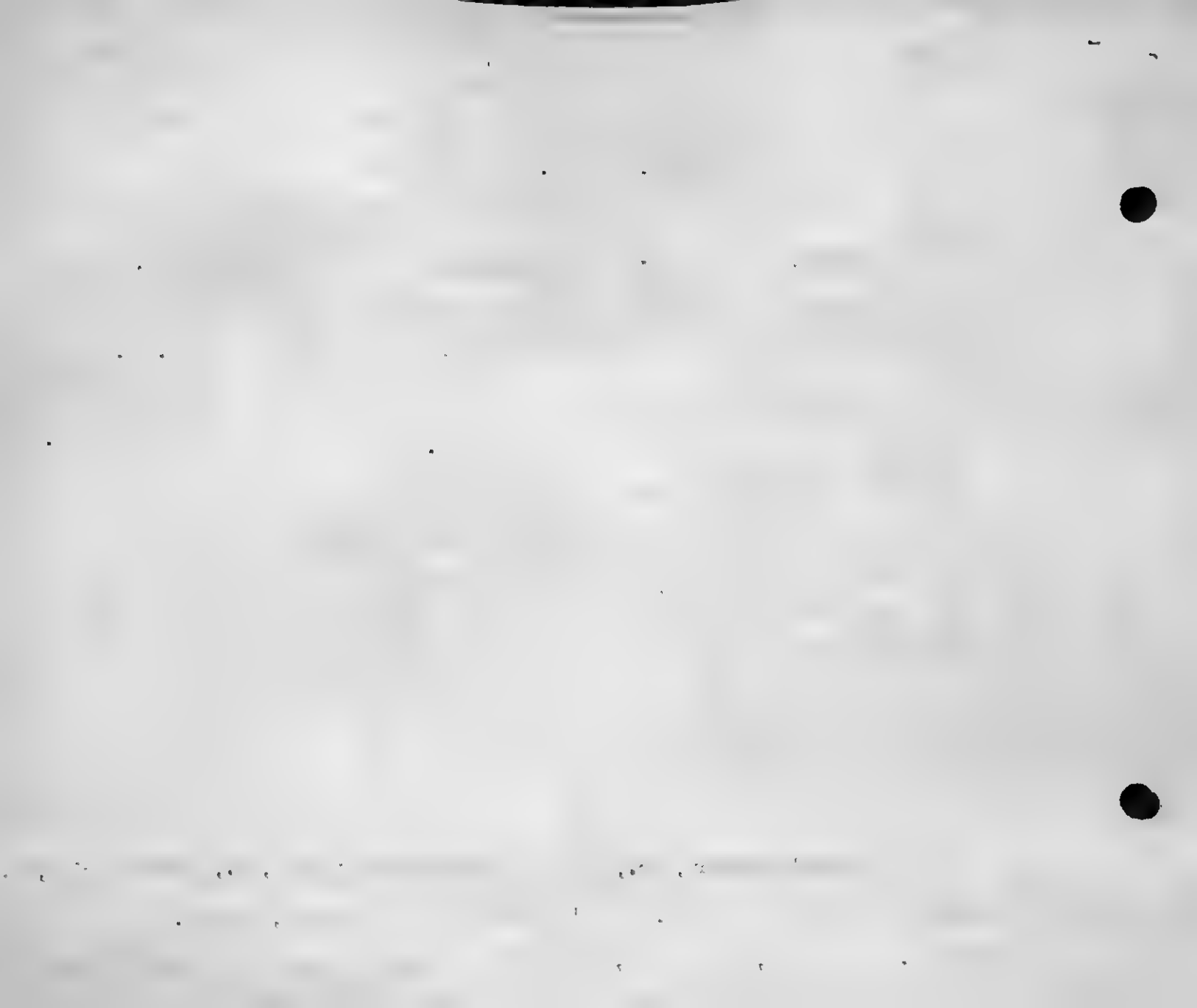
Cleared with medical examiner

17183

17179

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 1 yr. 11 Mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12907 Goodhill Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton d. STREET ADDRESS 12907 Goodhill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret E. Conyngham		4. DATE OF DEATH December 7, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1897
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE County & State, or foreign country Penna.		12. CITIZEN OF WHAT COUNTRY U. S.	
13. FATHER'S NAME Michael Jordan		14. MOTHER'S MAIDEN NAME Mary Barrett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Son William J. Conyngham Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Cerebrovascular accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes INTERVAL BETWEEN ONSET AND DEATH 1961			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1966 to Dec. 7, 1967 ; that (I) (we) last saw the deceased alive on Oct 27, 1967 , and that death occurred at 7:50 M, from the causes and on the date stated above.			
22a. SIGNATURE Raymond Bradshaw, Jr., M.D.		22b. DATE SIGNED Dec. 7, 1967	
22c. PHYSICIAN'S NAME (Type) Raymond Bradshaw, Jr., MD		22d. ADDRESS 345 University Blvd, W., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-11-67	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) (State) Hanover, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 11 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge	



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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b 1MO-9DA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KENSINGTON GARDENS						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK d. STREET ADDRESS 7204 MAPLE AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First OTHO Middle B. Last COOLEY						4. DATE OF DEATH Month DEC. Day 12 Year 1967					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 10-78		9. AGE (in years last birthday) 89 yrs.		10. FUNERAL 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY MAINTENANCE MAN		11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY Co. Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD COOLEY						14. MOTHER'S MAIDEN NAME LOUISE HUSTIN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 579-12-1291		17. INFORMANT Family of the deceased (same as above) Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4-5-1 DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-11 , 19 67 , to 12-12 , 19 67 , that (I) (we) last saw the deceased alive on 12-11 , 19 67 , and that death occurred at 2:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE Robert T. Thibadeau						ATTENDING PHYS. MD.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-12-67	
22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.						22d. ADDRESS 11000 Old Georgetown Rd. Rockville, Maryland					
23a. BURIAL CREMATION Removal (Specify)				23b. DATE THEREOF Dec. 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION (City, town or county) (State) Beallsville Md			
24. FUNERAL DIRECTOR Arthur Walters						25a. REC'D BY REGISTRAR 254		25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE DEC 18 1967											

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17185

17181

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 8 days		2 USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland 20777	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Joseph Ernest Cooney		4. DATE OF DEATH Month 12 Day 23 Year 19 67			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/06		9. AGE (In years last birthday) yrs. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed-disabled		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John J. Cooney		14. MOTHER'S MAIDEN NAME Mary A. French	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records, Olney, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure DUE TO (b) chronic congestive cardiac failure DUE TO (c) cirrhosis of the liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVA. BETWEEN ONSET AND DEATH 2 hours 2 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) lobar pneumonia, rt lower lung					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 67 , to 12/23 , 19 67 , that (I) (was) lost saw the deceased alive on 12/22 , 19 67 , and that death occurred at 3:23 PM from causes and on the date stated above.					
22a. SIGNATURE Charles S. Whitaker		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/24/67	
22c. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		22d. ADDRESS Clarksville, Maryland 21029			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-27-67	23c. NAME OF CEMETERY OR CREMATORY Union		23d. LOCATION (City or Town) (County) (State) Baltimore, Md. Montg. Md.	
24. FUNERAL DIRECTOR Higginbotham-Slack		ADDRESS Fellows City		25a. REC'D BY REGISTRAR DATE DEC 29 1967	
				25b. REGISTRAR'S SIGNATURE W. J. Judge	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17186

17182

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN 1b <u>43 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>3714 - Chesapeake St</u>			
3. NAME OF DECEASED (Type or print) <u>Walter Hunt Cottrell</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-86</u>	9. AGE (In years last birthday) <u>81</u> yrs.	10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>1</u> Min <u>0</u>		11. IF UNDER 24 HRS Hours <u>1</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>-</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Tabor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. cel.) <u>yes</u> <u>stat. given</u>				16. SOCIAL SECURITY NO. <u>578-62-2616</u>			
17. INFORMANT <u>Walter Morris Cottrell</u>				Address <u>1509 11th St. N.W.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <u>Pneumonia</u>							
DUE TO (b) <u>Tracheostomy</u>							
DUE TO (c) <u>Cancer of Larynx</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer of Prostate</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>Dec 2, 1967</u> that (I) (we) last saw the deceased alive on <u>Dec 2</u> 1967, and that death occurred at <u>7:10 AM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Robert N. Coale</u>				22b. DATE SIGNED <u>Dec 3, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>	
22d. ADDRESS <u>4429 Bradley Lane Chevy Chase Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-6-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>DEC 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	
5130 Wisc. Ave. N.W. Wash. D.C.							



CLEARED - Medical Examiner, L.S.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET
 BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSP.						d. STREET ADDRESS 7514 JACKSON AVE.			
3. NAME OF DECEASED (Type or print) First Middle Last IDA ANN CRAFT						4. DATE OF DEATH Month Day Year 12 - 30 1967			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-12-81		9. AGE (In years last birthday) yrs 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LESLIE LOPEMAN LOPEMAN						14. MOTHER'S MAIDEN NAME ANNIE BATCHLOR			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NONE				16. SOCIAL SECURITY NO NONE		17. INFORMANT DTR. Address EVELYN GREER - SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO cardiovascular heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) congestive failure (c) hypertension									INTERVAL BETWEEN ONSET AND DEATH 2
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12 19 67				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 1955 19 67 to 12/30/67 that (1) (we) last saw the deceased alive on Nov 5 19 67 , and that death occurred at 7:30 P.M. from causes and on the date stated above.									
22a. SIGNATURE Nas H. McElhannon						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Nas H. McElhannon						22d. ADDRESS 1401 Pk Rd 4th Fl. Balt. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Jan. 4, 1968		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION		25a. REC'D BY REGISTRAR N. G. BIRD	
24. FUNERAL DIRECTOR C. Glen Carter						ADDRESS 4444 Avenue		25b. SIGNATURE	
25. FUNERAL HOME Warner E. Pumphrey, Inc.						ADDRESS Silver Spring, Md.		DATE 12-30-67	

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VR A15 (4)
25M 1/67

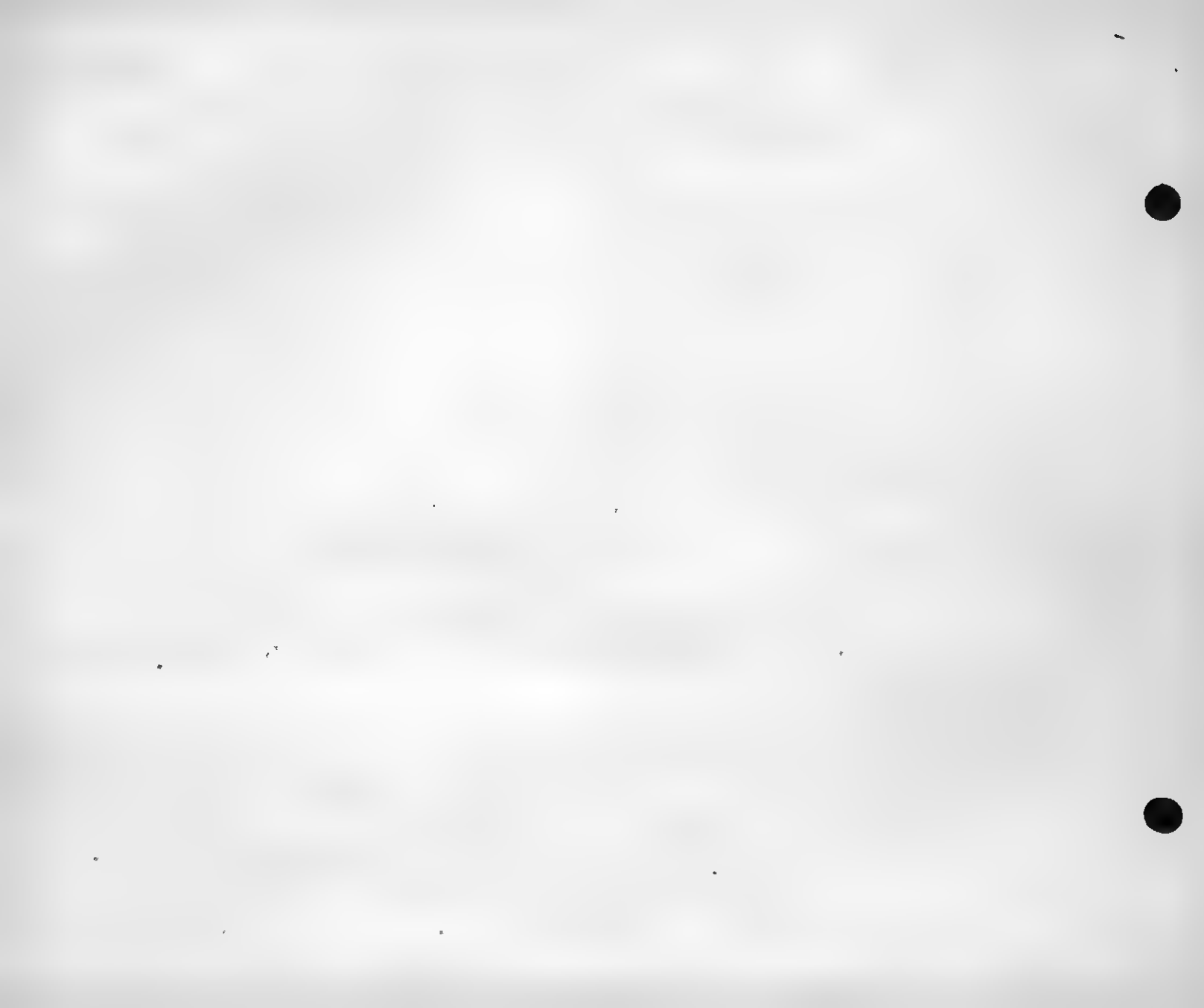
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17188

17188

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>9 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>5003 Alta Vista Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Gregory R. Crymes</u>		4 DATE OF DEATH <u>December 18, 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-6-03</u>
9 AGE (In years last birthday) <u>64</u> yrs		10a IF UNDER 1 YEAR Months Days 10b IF UNDER 24 HRS Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>William Riley</u>		14 MOTHER'S M maiden NAME <u>Lena M. Hall</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Heabond - Leonard Crymes</u>		Address <u>Same as above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO <u>Advanced coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Advanced coronary arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Thrombosis, right femoral artery; Thrombo-endo-arterectomy, 5hrs post-surg.</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 5, 1966</u> to <u>DEC 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>DEC 18, 1967</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Thomas F. O'Connor</u>		22b DATE SIGNED <u>DEC 18, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>THOMAS F. O'CONNOR</u>		22d ADDRESS <u>8218 Wisconsin Ave. Bethesda, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12-21-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>DEC 26 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 10&21 Film 396
12-29-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17187

1 PLACE OF DEATH a COUNTY <i>MONT.</i> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TARDONIA PARK</i> c LENGTH OF STAY IN THE <i>(3) 3 days</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) c STATE <i>WASHINGTON/D.C.</i> d CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Georges Co.</i> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>KENNETH</i> First Middle Last <i>WILLIAM Cummings</i>		4 DATE OF DEATH Month Day Year <i>12 16 1967</i>	
5 SEX <i>M</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>9-23-1903</i> 9 AGE (in years last birthday) yrs <i>64</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TRUCK DRIVER</i>		10b KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>	
11 BIRTHPLACE (State or foreign country) <i>VA.</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>WALTER Cummings</i>		14 MOTHER'S MAIDEN NAME <i>MARTHA CORNELL</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO <i>223-18-4835</i>	
17 INFORMANT <i>HOSPITAL RECORD</i> Address			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction;</i> DUE TO (b) <i>Coronary artery heart disease</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i> EXAMINER'S NAME (Type) <i>BELDEN R. REAP</i>		22. DATE SIGNED <i>DEC. 16, 1967</i>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>Dec 19, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St James Episcopal</i>	23d. LOCATION (City or town) (County) (State) <i>Rothman, Anne Md</i>
24 FUNERAL DIRECTOR <i>Hutchins Funeral Home</i>		25 REC'D BY REG STRAR <i>Charles Judge</i>	25b REG STRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17188

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) g. STATE Maryland		b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross		d STREET ADDRESS 2532 Ross Rd., Apt 101		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Mary Virginia Cunningham		4 DATE OF DEATH Dec 17 1967			
5 SEX F	6. COLOR OR RACE N	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/15/16	9 AGE (In years last birthday) 51/49 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cafeteria mgr		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME George Gennis		14. MOTHER'S MAIDEN NAME		12 CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.		17. INFORMANT Frank Cunningham, husband	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: 4301 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Thrombosis (b) Hypertensive Arteriosclerotic Heart Disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 1963, to 12/17, 1967 that (I) (we) last saw the deceased alive on 12/17 1967 and that death occurred at 9:02 M, from causes and on the date stated above.					
22a SIGNATURE Lawrence D. Marcus		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 12/18/67	
22c PHYSICIAN'S NAME (Type) LAWRENCE D. MARCUS, M.D.		22d ADDRESS 1111 SPRING STREET, S.S.M.D.			
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 12/21/1967	23c NAME OF CEMETERY OR CREMATORY Lincoln		23d LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR James R. Lisher		ADDRESS 1432 - You St N.W.		25a REC'D BY REGISTRAR DEC 27 1967	25b REGISTRAR'S SIGNATURE James R. Lisher

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

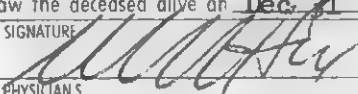
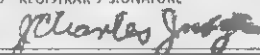
CERTIFICATE OF DEATH

17189

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>"</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN TB <u>1 day</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		d. STREET ADDRESS <u>3708 East West Highway</u>	
3 NAME OF DECEASED (Type or print) <u>David Hobson Deibler</u>		4. DATE OF DEATH <u>December 30 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-15-98</u>
9 AGE (in years last birthday) <u>69</u> yrs.		FUND 1 YEAR <u>30</u> Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David P. Deibler</u>		14. MOTHER'S MAIDEN NAME <u>Emma Huntzberger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>219-36-9900</u>	
17. INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular Disease (CVA)</u> DUE TO (b) <u>Coronary Heart Disease - Coronary Thrombosis</u> DUE TO (c) <u>26 hours</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic lymphatic leukemia; diabetes mellitus.</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>12:50 PM</u> , 19 <u>67</u> , to <u>Dec 30</u> , 1967, that (I) (we) last saw the deceased alive on <u>Dec 30</u> , 1967, and that death occurred at <u>1:46 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Aaron H. Traum</u>		22b. DATE SIGNED <u>Dec 30, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum, M.D.</u>		22d. ADDRESS <u>8237 Georgia Ave Silver Spring Maryland Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/3/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., Washington, D. C.</u>		25a REC'D BY REGISTRAR <u>JAN 5 1968</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

CERTIFICATE OF DEATH

17190

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE District of Columbia b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN 1b 19 Days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e STREET ADDRESS 11 Starboard Green	
3 NAME OF DECEASED (Type or print) Mariano Delmundo		4. DATE OF DEATH Month December Day 31 Year 19 67	
5. SEX Male	6. COLOR OR RACE Malayan	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1924
9. AGE (In years last birthday) 43 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Imus Cavite, P.I.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Pebronilo Delmundo		14 MOTHER'S MAIDEN NAME Antonia Samson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1946-1967		16. SOCIAL SECURITY NO. 575-32-4201	
17. INFORMANT Mrs. Basilia Delmundo		11 Starboard Green S.W. Washington, D.C.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Duodenal Ulcer with Perforation DUE TO (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 12 , 19 67 , to Dec 31 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec 31 , 19 67 , and that death occurred at 7:00 PM , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED Jan 1, 1968	
22c. PHYSICIAN'S NAME (Type) W.R. HIX, M. D.		22d. ADDRESS Naval Hospital Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/5/68	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Va
24 FUNERAL DIRECTOR Falls Church Funeral Home, Falls Church, Va		25a. REC'D BY REGISTRAR JAN 8 1968	25b. REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

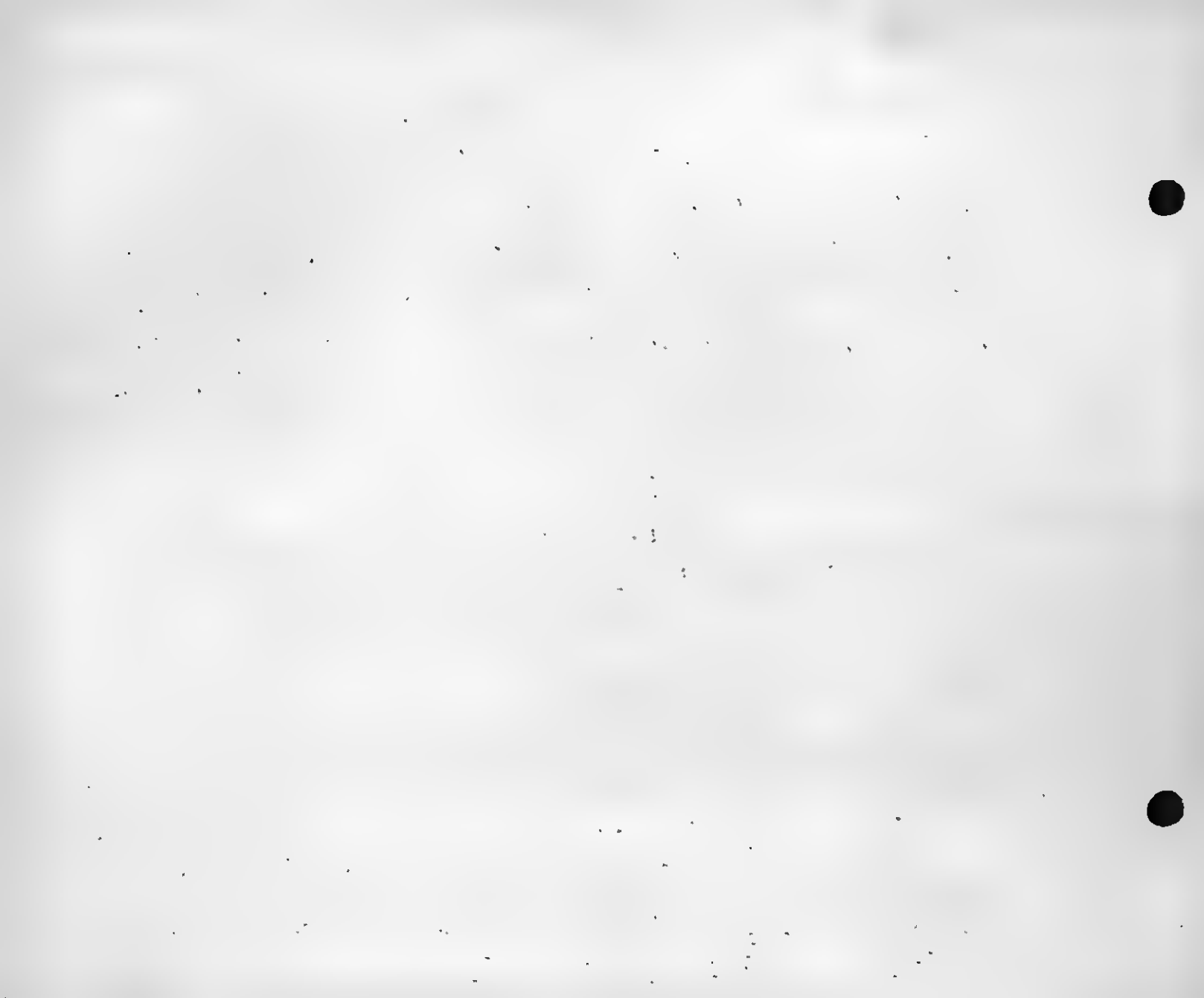
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>3412 Quezada St NW</u>	
3 NAME OF DECEASED (Type or print) <u>Theodore North Denslow</u>		4 DATE OF DEATH <u>Dec. 24</u> 19 <u>67</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>Caucasian</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/4/82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOLS</u>	9. AGE (In years last birthday) <u>85</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>VERMONT</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HERBERT M. DENSLAW</u>		14. MOTHER'S MAIDEN NAME <u>ANNA M. CLMSTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN NONE</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>	
17. INFORMANT <u>JOSEPHINE DENSLAW</u>		Address <u>WASH D.C. 3412 QUEZADA ST NW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>491A</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7-10 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 1</u> , 19 <u>67</u> , to <u>12/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>67</u> , and that death occurred at <u>1:34</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>G. Leonard Gold</u> M.D.		22b. DATE SIGNED <u>12/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold, M.D.</u>		22d. ADDRESS <u>8641 Colesville Road, Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>12/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>F. LINCOLN CROWNEY</u>	23d. LOCATION (City or Town) (County) (State) <u>COLUMBIA MARINE MIDDLE MD</u>
24. FUNERAL DIRECTOR <u>N. H. CHAMBERS Co.</u>		25a. REC'D BY REGISTRAR <u>8665 Georgia Ave, Silver Spring Md.</u>	25b. REGISTRAR'S SIGNATURE <u>DATE DEC 29 1967</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) MARGARET EDITH DONNELLY						2a. DATE OF DEATH Month Dec Day 27 Year 1967			2b. HOUR 8:30 PM			
3. SEX F		4. RACE CAUC		5. DATE OF BIRTH 12-23-1880		6. AGE (In years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0		
7a. BIRTHPLACE (State or foreign country) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNIVERSITY NURSING HOME				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
3a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 407 MANSFIELD RD		
14. FATHER'S NAME First JULIUS FREDERICK Middle WALTERS Last WALTERS				15. MOTHER'S MAIDEN NAME First JULIA Middle CHRISTINA Last SCHMEL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) ? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 219-54-9858		17. INFORMANT George Donnelly Address 407 Mansfield Rd, Silver Spring, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4221 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) General Debility DUE TO, OR AS A CONSEQUENCE OF (c) as above										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) malnutrition												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Aug , 19 67 , to Dec 27 , 19 67 , that (I) (we) last saw the deceased alive on Dec 27 , 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Russell C. Bufalino M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED Dec 27, 1967						
22d. PHYSICIAN'S NAME (Type) RUSSELL C. BUFALINO, M.D.						22e. ADDRESS 1429 University Blvd W. SS. Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Jan 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION (City or Town) Kalamazoo (County) Pennsylvania (State)						
24. FUNERAL DIRECTOR George Donnelly ADDRESS 407 Mansfield Rd, Silver Spring, Md.						25a. REC'D BY REGISTRAR 8 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]				



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VR A15 (1)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17195

17193

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>15 Hrs-35 min</u>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barrett Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deebleman Hospital</u>		d. STREET ADDRESS <u>4711 Oxford St</u>	
3 NAME OF DECEASED (Type or print) <u>William J. DOVE</u>		4 DATE OF DEATH Month <u>Dec</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1/30/90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>none</u>		12. CITIZEN OF WHAT COUNTRY? <u>none</u>	
13. FATHER'S NAME <u>none</u>		14. MOTHER'S MAIDEN NAME <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-12-5813</u>	
17. INFORMANT <u>none</u>		Address <u>none</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Failure</u> DUE TO <u>Branchio pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Branchio pneumonia</u> DUE TO <u>Branchio pneumonia</u> (c) <u>Branchio pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis - Emphysema</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) (County) (State) <u>none</u>
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 5</u> , 19 <u>67</u> to <u>Dec 8</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Dec 7</u> , 19 <u>67</u> , and that death occurred at <u>4:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Thibadeau</u>		22b. DATE SIGNED <u>12-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		22d. ADDRESS <u>11000 OLD GEORGETOWN RD ROCKVILLE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkland Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			



CERTIFICATE OF DEATH

17196

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u> <u>PARK</u> c LENGTH OF STAY IN 1b <u>2 weeks</u>		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHAWER SPRING</u>	
3 NAME OF DECEASED (Type or print) <u>ELIZABETH GRACE DOWNEY</u> First Middle Last 4 DATE OF DEATH <u>DEC. 28</u> 19 <u>67</u> Month Day Year		5 SEX <u>F</u> 6 COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. & HOSP.</u>		d STREET ADDRESS <u>600 CIST AVE.</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. AGE (In years last birthday) <u>85</u> yrs		10. BIRTHPLACE (County & State, or foreign country) <u>DIST. OF COLUMBIA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DIST. OF COLUMBIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES VOSS</u>		14. MOTHER'S MAIDEN NAME <u>EDITH RYDER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>219 52-5444</u>	
17. INFORMANT <u>CHARLES J. Downey</u> Address <u>1st home</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>492X</u> DUE TO <u>Spontaneous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Spontaneous</u> (c) <u>Fractured leg</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/5/67</u> , 19 <u>67</u> , to <u>12/28/67</u> , that (I) (we) last saw the deceased alive on <u>12/21/67</u> , and that death occurred at <u>7:20</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Chas H. U. L. H. O. N.</u>		22b DATE SIGNED <u>12/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas H. U. L. H. O. N.</u>		22d. ADDRESS <u>740 13th St NW Wash DC</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>202-30-176</u>		23b DATE THEREOF <u>12/30/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>St. John Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Forest Hill, Maryland</u>	
24 FUNERAL DIRECTOR <u>John B. Thomas</u>		25a REC'D BY REG. STAR DATE <u>JAN 2 1968</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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17197

CERTIFICATE OF DEATH

17195

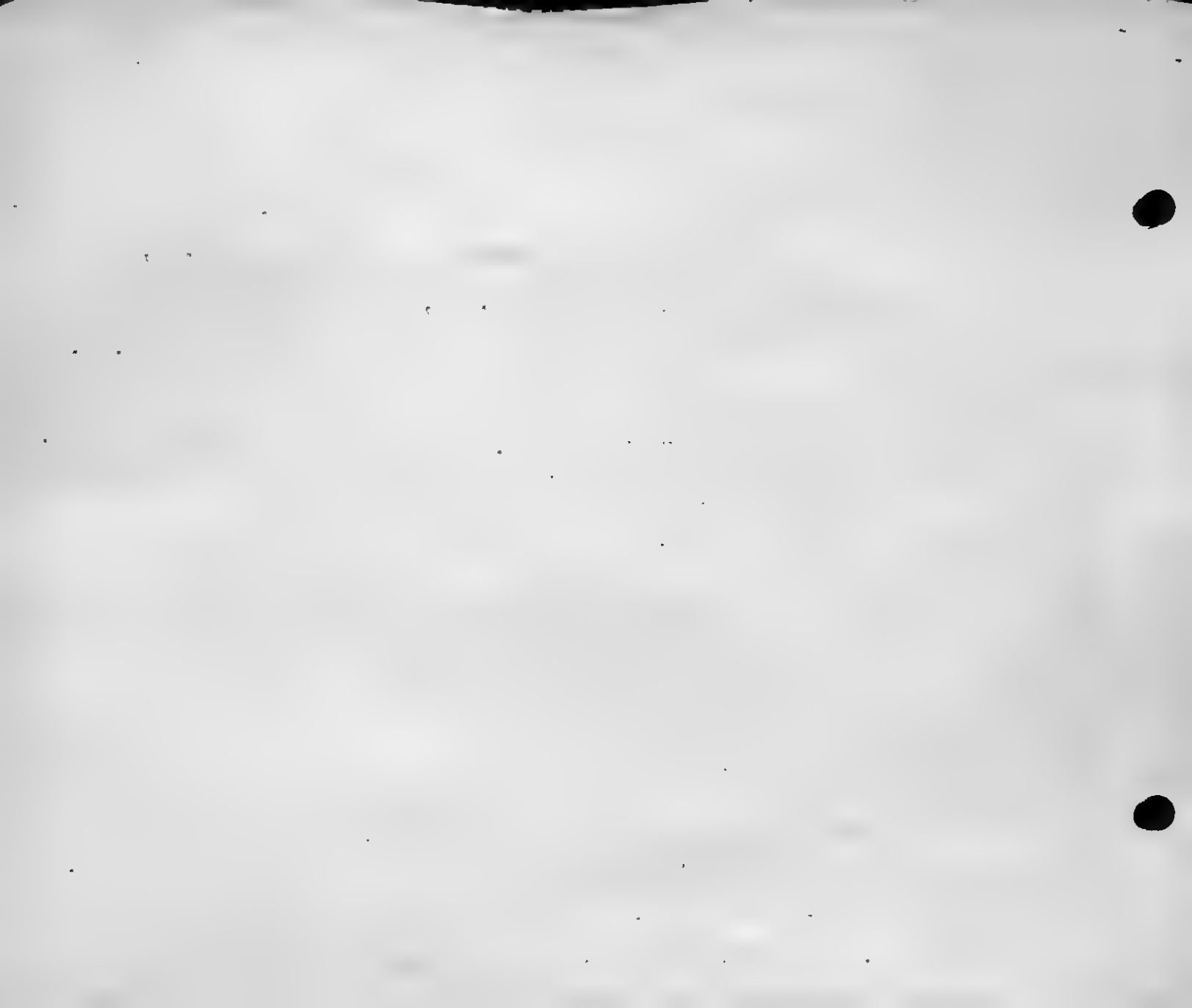
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital Bethesda		d. STREET ADDRESS 8413 Gibbons Drive	
3 NAME OF DECEASED (Type or print) First BRIAN Middle KEITH Last DOYLE		4. DATE OF DEATH Month December Day 1 Year 1967	
5 SEX male	6 COLOR OR RACE cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 14 Nov 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs 0 Months 14 Days 14 Hours 14 Min.
11 BIRTHPLACE (County & State, or foreign country) Andrews Air Force Base		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Thomas A. DOYLE		14. MOTHER'S MAIDEN NAME Martha B. Blanchard	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16 SOCIAL SECURITY NO NONE	
17 INFORMANT Father 8413 Gibbons Dr.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CONGENITAL HEART DEFECT 1542 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 17 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour 0 m 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 28 NOV , 19 67 , to 1 DEC , 19 67 , that (I) (we) last saw the deceased alive on 1 DEC , 19 67 , and that death occurred at 2:25 PM from causes and on the date stated above.			
22a. SIGNATURE LT T.E. KELLY, MC, USN		22b DATE SIGNED 3 DECEMBER 1967	
22c PHYSICIAN'S NAME (Type) LT T.E. KELLY, MC, USN		22d ADDRESS NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-5-67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or town) (County) (State) Arlington MARY, Virginia
24. FUNERAL DIRECTOR R.A. PUMPHREY 7557 WISCONSIN AVE BETHESDA, MD		25a. REC'D BY REGISTRAR DEC 7 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. Gandy</i>

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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3204 Parkview Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 3204 Parkview Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First NORA Middle DUFFY Last DUFFY				4. DATE OF DEATH Month Dec. Day 5 Year 1967									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 10, 1884		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Ireland				12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Patrick Ryan						14. MOTHER'S MAIDEN NAME Mary Walsh							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 142-38-3130				17. INFORMANT Daughter Mrs. Stephen Timko				Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 2x DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH 2 days ?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____													
21. I certify that (I) (this hospital) attended the deceased from Feb. 1967 to 5 Dec., 1967 that (I) (we) last saw the deceased alive on 3 Dec., 1967 , and that death occurred at 1:55 AM from the causes and on the date stated above.													
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) WILLIAM D. AUD						22b. DATE SIGNED 12/5/67 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS () - 9006 Colfaxville Rd. Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-9-67		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				23d. LOCATION (City, town or county) (State) Trenton, New Jersey			
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE DEC 7 1967 Charles Judge							



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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
19159
CERTIFICATE OF DEATH
17197

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>805 Accola Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JACOB</u> Middle <u>DUKOFF</u> Last <u>DUKOFF</u>		4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/93</u> 9. AGE (in years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERSCHEL DUKOFF</u>		14. MOTHER'S MAIDEN NAME <u>RACHAEL POLISAR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>087-01-5007</u>	
17. INFORMANT <u>BERNARD KUFMAN</u> Address <u>1009 N. BELGRADE RD SILVER SPRING MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Co of the Bladder & Urinary obstruction</u> DUE TO (c) <u>accid</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>accid</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>11/23/1967</u> to <u>12/4/1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 4 1967</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Russell C. Bufalino</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino, M.D.</u>		22b. DATE SIGNED <u>Dec 5, 1967</u> 22d. ADDRESS <u>1429 Univ. Blvd. W.</u>	
23a. BURIAL, CREMAT. DN, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-6-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GEO. LEVASH. CEM.</u>		23d. LOCATION (City, town or county) (State) <u>HATTVILLE MD</u>	
24. FUNERAL DIRECTOR <u>Charles J. Furea Home</u> ADDRESS <u>4217 9th St. U.W.</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Furea</u>	

17200

CERTIFICATE OF DEATH

17198

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN TB <u>15 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e STREET ADDRESS <u>6928 Ruskin Street</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Gary Eugene Dunaway</u>		4 DATE OF DEATH Month Day Year <u>December 7 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 March 1961</u>
9 AGE (In years last birthday) <u>6 yrs</u>		10. IF UNDER YEAR Months Days Hours Min. <u>6 yrs</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Walter J. Dunaway</u>		14. MOTHER'S MAIDEN NAME <u>Christine Saunders</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>	
17 INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Hypoxia</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Cystic Fibrosis of the Pancreas</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>3 Weeks</u> <u>6 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 22, 1967</u> , to <u>Dec. 7, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 7, 1967</u> , and that death occurred at <u>6:18 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stuart Handwerker</u> M.D.		22b. DATE SIGNED <u>12/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stuart Handwerker, M. D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23c NAME OF CEMETERY OR CREMATORY <u>Falling River Church</u>	
23b DATE OF BURIAL, CREMATION, REMOVAL <u>12/10/67</u>		23d. LOCATION (City or Town) (County) (State) <u>Brookneal Campbell va.</u>	
24 FUNERAL DIRECTOR <u>Stuart Handwerker</u>		25a. RECEIVED BY REGISTRAR <u>DEC 13 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17199

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6015 Massachusetts Ave</u>		d. STREET ADDRESS <u>6015 Massachusetts</u>	
3. NAME OF DECEASED (Type or print) <u>Noomi S. Dunman</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11, 1888</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Dora Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>578 68 9820</u>	
17. INFORMANT <u>Olin E Teague Daughter</u>		Address <u>same above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>26 hours</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>12/24/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>12-29-67</u>	<u>Mt Olivet</u>	<u>Fort Worth Texas</u>
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>		Address <u>7557 Wisconsin Ave Bethesda, Md</u>	
25a. REC'D BY REGISTRAR DATE <u>DEC 29 1967</u>		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

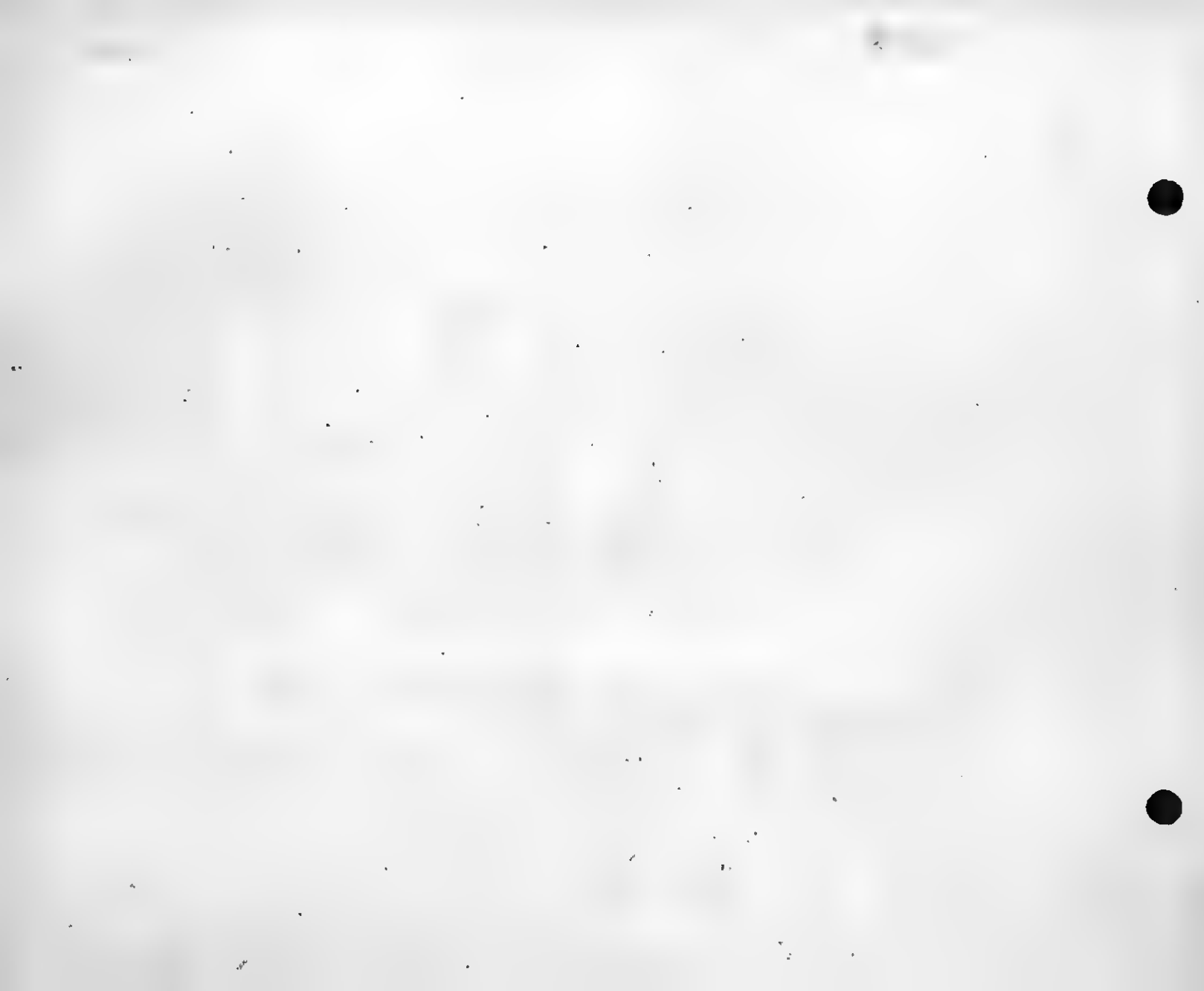
17202

17200

1. DECEASED-NAME (Type or print) Thomas A. Dunnington			2a. DATE OF DEATH Month Dec. Day 30 Year 1967			2b. HOUR 3:30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5-3-16		6. AGE (In years last birthday) 51 YRS	
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10419 Lorain Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Government		12b. KIND OF BUSINESS OR INDUSTRY Contract	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13e. STREET AND NUMBER 10419 Lorain Ave. /	
14. FATHER'S NAME First Middle Last G. Howard Dunnington			15. MOTHER'S MAIDEN NAME First Middle Last Mary H. Miller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) Yes (If yes give year or dates of service) WWII		16b. SOCIAL SECURITY NO 677-05-1176		17. INFORMANT Mrs. Frances F. Dunnington		Address Same as	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Mon _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from 1962 to 12/30, 1967 , that (I) (we) last saw the deceased alive on 12/19, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A.F. Thibadeau MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) A.F. THIBADEAU				22e. ADDRESS 10111 Colesville Rd. SIL. SP. MD.			
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE 1-3-68		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		23d. LOCATION (City or Town) (County) (State) FOREST GLEN, MONT. MD.	
24. FUNERAL DIRECTOR FRANCIS J. COLLINS		ADDRESS 3821 14th. ST. N.W.		25a. REC'D BY REGISTRAR JAN 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17203

17201

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>1 HR 50 MIN</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hospital</u>		d STREET ADDRESS <u>Kensington Gardens Nurs. Home</u>	
3 NAME OF DECEASED (Type or print) <u>Sally</u> First <u>MAY</u> Last <u>Eaton</u>		4 DATE OF DEATH <u>Dec 23</u> 19 <u>67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-11-1878</u>
9 AGE (in years last birthday) <u>89</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Co Maryland Frederick</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>Samuel Wooten</u>		14 MOTHER'S MAIDEN NAME <u>Sarah Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>214-5402-82</u>	
17 INFORMANT <u>Don Ralph Eaton</u>		Address <u>Laguardia Md 2221 Beauty dr</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> DUE TO (b) <u>ASCVD</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>yes</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1967</u> , to <u>23 Dec 1967</u> , that (I) (we) last saw the deceased alive on <u>23 Dec 1967</u> , and that death occurred at <u>9:00</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Horace W. Bender</u> M.D.		22b. DATE SIGNED <u>12/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR FRED W. GILL</u> <u>Horace W. Bender</u>		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>12-26-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Faith United Ch/Christ Cem</u>	23d LOCATION (City or Town) (County) (State) <u>Charlesville Md</u>
24. FUNERAL DIRECTOR <u>Raymond E. Crea</u>		25a REC'D BY REGISTRAR <u>DEC 27 1967</u>	
25b REGISTRAR'S SIGNATURE <u>James H. Hurdmont</u>		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17202

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
c. LENGTH OF STAY IN 1b <u>DoA</u>		d. STREET ADDRESS <u>11409 Newport Mill Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>E</u> Last <u>Elmer</u>		4 DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/8/1895</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Keenest Statistical Clerk Dept.</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Bethesda</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Thomas K. Longene</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>578-46-5671-B</u>	
17 INFORMANT <u>Roy A. Elmer</u>		<u>11409 New Mill Road Wheaton, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X</u> DUE TO <u>Cardiac Arrest</u> (b) <u>Rheumatic heart disease</u> DUE TO <u>60 years</u> (c) <u>last.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 16</u> , 19 <u>62</u> , to <u>8/12/6, 1967</u> , that (I) (we) lost saw the deceased alive on <u>August 4</u> 19 <u>67</u> , and that death occurred at <u>PM</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Jack P. Segal</u> M.D.		22b DATE SIGNED <u>12/6/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Jack P. Segal</u>		22d ADDRESS <u>5323 Conn Ave NW Wash DC</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Dec. 9, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>
24 FUNERAL DIRECTOR <u>C. Glen Carter Warner E. Pumphrey, Inc.</u>		25a REC'D BY REGISTRAR <u>DEC 11 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by Medical Examiner's Office

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11205											
11203											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10611 Lockridge Drive</u>						d. STREET ADDRESS <u>10611 Lockridge Drive</u>					
3. NAME OF DECEASED (Type or print) <u>Susan Tilton Ellis</u>						4. DATE OF DEATH <u>Dec 15 - 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6 - 1906</u>		9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dayton, Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>					
13. FATHER'S NAME <u>John W. Tilton</u>						14. MOTHER'S MAIDEN NAME <u>Mary Belle Marr</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>579 48 4812</u>					
17. INFORMANT <u>Warren Ellis - Samp</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Pulmonary Embolus</u> 191.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Abdominal Carcinomatosis</u> (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 15</u> to <u>Dec 15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 11</u> , 19 <u>67</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>James W. Egan</u>						22b. DATE SIGNED <u>December 15, 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>James W. Egan</u>						22d. ADDRESS <u>5413 Cedar Lane - Bethesda</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
23b. DATE THEREOF <u>Dec 18, 1967</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>											
23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey Inc.</u>											
25a. REC'D BY REGISTRAR <u>DEC 21 1967</u>											
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

MEDICAL EXAMINER
NOTIFIED WILL APPROVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17206										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17204									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print) First Middle Last <i>SIMMA - ELVOVE</i>										2a. DATE OF DEATH Month Day Year <i>12-31-1967</i>										2b. HOUR <i>8:30 PM</i>									
3. SEX <i>FEMALE</i>					4. RACE <i>CAUC.</i>					5. DATE OF BIRTH <i>10/20/1879</i>					6. AGE (In years last birthday) <i>88</i> YRS					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <i>18</i>					IF UNDER 24 HRS. HOURS MIN <i>18</i>				
7a. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>					7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <i>MONTGOMERY</i> MD														
10. CITY OR TOWN OF DEATH <i>NHEATON Md.</i>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>UNIVERSITY NURSING HOME</i>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSEWIFE</i>					12b. KIND OF BUSINESS OR INDUSTRY —														
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>MD</i> DC					13b. COUNTY <i>DC.</i>					13c. CITY OR TOWN <i>N.W. WASH</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER <i>4425 8th St., N.W.</i>									
14. FATHER'S NAME First Middle Last <i>SOLOMON - ELVOVE</i>					15. MOTHER'S MAIDEN NAME First Middle Last <i>BARSEVA BARSKY</i>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>					16b. SOCIAL SECURITY NO <i>599-62-9649</i>					17. INFORMANT Address <i>ETHEL ELVOVE - Same as 13</i>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <i>Myocardial Heart Failure</i>																				<i>immediate</i>									
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) <i>Arteriosclerotic Heart Disease</i>																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus</i>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <i>11-24-</i> , 19 <i>65</i> , to <i>12-31-</i> , 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>11-28</i> , 19 <i>67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>Samuel A. Hillman MD.</i>										22c. DATE SIGNED <i>1/1/68</i>																			
22d. PHYSICIAN'S NAME (Type) <i>SAMUEL A. HILLMAN</i>										22e. ADDRESS <i>8829 FLOWER AVE SILVER SPRING MD 20901</i>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>					23b. DATE <i>1-2-1968</i>					23c. NAME OF CEMETERY OR CREMATORY <i>GEO WASH Cem. Inc</i>					23d. LOCATION (City or Town) (County) (State) <i>HYATTSVILLE MD</i>														
24. FUNERAL DIRECTOR <i>Gooding Funeral Home</i>										ADDRESS <i>4217-9th Ave</i>					25a. REC'D BY REGISTRAR <i>JA</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERS' BLVD</u>	
c. LENGTH OF STAY IN 1b <u>1 DAY</u>		d. STREET ADDRESS <u>709 S. Washington St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>ELIZABETH T. EVANS</u>		4. DATE OF DEATH <u>December 6 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 22-1891</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Hospital Administrator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WESLEY WARD THOMPSON</u>		14. MOTHER'S MAIDEN NAME <u>ALICE REBECCA WARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>212-32-1705A</u>	
17. INFORMANT <u>MRS AMY BEVAN HAUDE DE GRACE MD</u>		Address <u>656 OTSEGOSA</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 MOS</u> (c)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/67</u> to <u>12/6/67</u> , that (I) (we) last saw the deceased alive on <u>12/6/67</u> , and that death occurred <u>12:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Henry C. Scruggs MD</u>		22b. DATE SIGNED <u>12/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY C SCRUGGS MD</u>		22d. ADDRESS <u>5413 Cedar Lane Bethesda Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>DEC 11 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>HAVERDE GRACE MD</u>
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7208

17206

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney, Md.</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		d. STREET ADDRESS <u>Washingtonian Towers Apt 1106</u>	
3 NAME OF DECEASED (Type or print) <u>RICHARD</u> First <u>WALTER</u> Middle <u>EVANS</u> Last <u>JR.</u>		4 DATE OF DEATH Month <u>12</u> Day <u>08</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/24/29</u>
9. AGE (in years last b'day) <u>38</u> yrs		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bondsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>salesman</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>California</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard W. Evans Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Whold</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Hospital records</u>		Address <u>Olney, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EXSANGINATION, Acute</u> DUE TO (b) <u>ESOPHAGEAL VARICES</u> DUE TO (c) <u>Cirrhosis, Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Congestion Heart Failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 20, 1967</u> to <u>Dec. 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec. 8, 1967</u> , and that death occurred at <u>11:47 p.m.</u> , from causes on and the date stated above			
22a. SIGNATURE <u>Jack Shumacher</u>		22b. DATE SIGNED <u>12-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Jack Shumacher</u>		22d. ADDRESS <u>105 Russell Ave., Gaithersburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-12-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Faithsville Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Faithsville Md</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. RECEIVED BY REGISTRAR <u>Ernest C. Gartner</u>	
ADDRESS <u>Gaithersburg, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17209

CERTIFICATE OF DEATH

17207

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Ohio b. COUNTY Mahoning			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN It 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Struthers			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md.				d. STREET ADDRESS 302 Maplewood Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Mary Middle Ann Last Fabek				4. DATE OF DEATH Month December Day 3 Year 1967			
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 13 August 1957		9 AGE (In years last b'day) 10 yrs	FUND 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY ---		11 BIRTHPLACE (County & State, or foreign country) Ohio		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Fabek				14. MOTHER'S MAIDEN NAME Ann Susany			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Low cardiac output DUE TO Post operative closure atrial septal defect, (b) mitral valve replacement, subaortic infundibulectomy DUE TO Congenital atrial septal defect, mitral valve (c) replacement, subaortic stenosis							INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 days 10 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 26 November 1967 to 3 December 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3 December 1967 , and that death occurred at 7:25 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Rudolf N. Staroscik</i>				M.D. ATTENDING PHYS <input type="checkbox"/> A.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 3 December 1967	
22c. PHYSICIAN'S NAME (Type) Rudolf N. Staroscik, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-6-67		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City or town) (County) (State) Youngstown, Ohio	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DEC 7 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 17210 CERTIFICATE OF DEATH 17208 </div>											
<div style="display: flex; justify-content: space-between;"> Montgomery CERTIFICATE AMENDED Montgomery, Md. </div>											
1. PLACE OF DEATH COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if not at home, residence before admission) a. STATE 2617 Blue Ridge Ave. b. COUNTY Wheaton, Md.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 4 yrs - 5 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium						d. STREET ADDRESS				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First: Alfonso, Middle: Fagnani, Last: Fagnani						4. DATE OF DEATH Month: 12, Day: 10, Year: 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-2-1893		9. AGE (In years last birthday) 74 yrs		IF UNDER 1 YEAR Months: Days: Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed				10b. KIND OF BUSINESS OR INDUSTRY Mason Contractor		11. BIRTHPLACE (County & State or foreign country) Italy				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ANTHONY FAGNANI						14. MOTHER'S MAIDEN NAME ROSE UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO 068-07-7234		17. INFORMANT Pauline Fagnani 2617 Blue Ridge Ave. Wheaton, Md.					
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b) and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) VISCERAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)										INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome 3 1/2 yrs; Proliferative Metastasis											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June, 1951, to Dec. 10, 1967, that (I) (we) last saw the deceased alive on Dec. 10, 1967, and that death occurred at 9:40 P.M. from causes and on the date stated above.											
22a. SIGNATURE Bertram F. Schaefer M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Dec. 10, 1967			
22c. PHYSICIAN'S NAME (Type) 1780 Mass. Ave. N.W. Wash. D.C.						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 13 DEC. 1967		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION (City or Town) (County) (State) SILVER SPRING MD.					
24. FUNERAL DIRECTOR RINALDI FUNERAL HOME 7400 GEORGIA AVE. N.W.						ADDRESS DC 20012		25a. REC'D BY REGISTRAR DATE DEC 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

DOCUMENTS ACCEPTED AS SUPPORTING EVIDENCE

1. To change no
 from no
 to yes

2. To change _____
 from _____
 to _____

Evidence returned _____ 19____ by _____

7

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
17211						17209					
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital						d. STREET ADDRESS 1714 Dublin Dr.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Stanley Middle Brooks Last Fairfax						4. DATE OF DEATH Month December Day 19 Year 1967					
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 6/3/09		9 AGE (In years, last birthday) 58 yrs		IF UNDER 1 YEAR Months 19 Days 67 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Soldiers Govt. Home		11 BIRTHPLACE (State or foreign country) USA				12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME						14 MOTHER'S MAIDEN NAME					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. II				16 SOCIAL SECURITY NO		17 INFORMANT Stepson, John Haas		Address 1714 Dublin Dr. Sil. Spr., Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Acute Coronary Insufficiency with fibrillation and Heart Block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery Heart Disease (c) Coronary Artery Heart Disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21 I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22. DATE SIGNED DEC. 20, 1967						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-23-67		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery				23d. LOCATION (City or town) (County) (State) Wash., D.C.	
24 FUNERAL DIRECTOR Rinaldi Funeral Home, 7400 Georgia Ave.						ADDRESS Wash., DC		25a. REC'D BY REGISTRAR DEC 26 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17210

1 PLACE OF DEATH a COUNTY MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c LENGTH OF STAY IN 1b DOA		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSP.		d STREET ADDRESS 8110 TAHONA DR	
3 NAME OF DECEASED (Type or print) First ROBERT Middle HENRY Last FALES		4 DATE OF DEATH Month 12 Day 22 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) 21 yrs
9 BIRTHPLACE (State or foreign country) MARYLAND		10 CITIZEN OF WHAT COUNTRY? U.S.A.	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME FRED L. FALES		14 MOTHER'S MAIDEN NAME LOLA V. JAMESON	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO WM L. FALES, Route #1, HAGERSTOWN, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory failure due to DUE TO (b) Carbon monoxide intoxication DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH Deceased overcome by fumes from truck motor running in closed garage		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Garage	
20c TIME OF INJURY Month Day Year Hour a.m. 8:00 12-22 1967		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> 20e PLACE OF INJURY (Home farm factory, street or like place, etc.) Silver Spring Montg. Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED DEC. 22, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER DEC. 22, 1967	
23a BURIAL, CREMATION, REMOVAL (Specify) Buried	23b DATE THEREOF Dec 26, 1967	23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d LOCATION (City or town) (County) (State) Hagerstown Md
24 FUNERAL DIRECTOR Takoma Funeral Home Inc. of Washington, 254 Canal St.		25a REC'D BY REGISTRAR DEC 27 1967	
25b REGISTRAR'S SIGNATURE [Signature]			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>8410 PARKCREST DR.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANN (NMN) FELDMAN</u>		4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-1895</u>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>HARRIS SILVERSTEIN</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE MINNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOC. A. SECURITY NO. <u>577-32-6117</u>	
17. INFORMANT <u>MR HERMAN FELDMAN (HUSBAND)</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Tamponade due to</u> DUE TO (b) <u>Dissecting aneurysm of</u> DUE TO (c) <u>ascending Aorta</u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u></u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> min <u>0</u> pm <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>DEC. 28, 1967</u>	
ACTUAL SIGNATURE <u>Belden R. Neap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. NEAP M.D.</u>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-29-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NATL MEMORIAL PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH VA.</u>	
24. FUNERAL DIRECTOR <u>Edwards Funeral Home</u>		ADDRESS <u>4217 9th St NW</u>	
25a. REC'D BY REG. CLERK <u>JAN 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>James H. Judge</u>	

CERTIFICATE OF DEATH

17212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Colonial Villa Nursing Home</u>		d. STREET ADDRESS <u>862 Azalea Drive</u>	
3. NAME OF DECEASED (Type or print) <u>DAVID</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1897</u>
9. AGE (In years last birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Men's Furnishings</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Feldman</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Cohen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Seymour Feldman</u>		Address <u>same as 2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A.S.H.D. acute myocardial infarction</u> DUE TO (b) <u>Chronic coronary artery disease</u> DUE TO (c) <u>17 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>17 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>12/20</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>12/10</u> , 19 <u>67</u> , and that death occurred at <u>10:30 PM</u> , from causes on and the date stated above.			
22a. SIGNATURE <u>Herbert Wechsler</u> M.D.		22b. DATE SIGNED <u>12/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Herbert Wechsler</u>		22d. ADDRESS <u>1800 Eye St NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church Va.</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home 4217 9th St., N.E.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 26 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Med. Examiner - W. R. Rupp

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 PLACE OF DEATH a. COUNTY MONTGOMERY					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM					d STREET ADDRESS 7206 Flower Ave				e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MARIA AMELIA FERNANDEZ					4 DATE OF DEATH Month 12 Day 2 Year 1967					
5 SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-24		9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min 0		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor			10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) CUBA			12 CITIZEN OF WHAT COUNTRY? CUBA		
13 FATHER'S NAME Diego Fernandez			14. MOTHER'S MAIDEN NAME Antonia Maria Paz							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO		17 INFORMANT 11422 Rokeby Ave., Kensington Md. Carlos Sera Brother-in-law					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 170X Probable Pulmonary Embolus IMMEDIATE CAUSE (a) DUE TO Adenocarcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/4/66 , 19 66 , to 12/2 , 19 67 , that (I) (we) last saw the deceased alive on 11/29 19 67 , and that death occurred at 10:15 AM , from causes and on the date stated above										
22a. SIGNATURE G. Leonard Gold					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 12/2/67			
22c PHYSICIAN'S NAME (Type) G. Leonard Gold					22d ADDRESS 9801 Georgia Ave., Silver Spring, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 12/5/67		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven			23d LOCATION (City or Town) (County) (State) Silver Spring, Md.			
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home					ADDRESS 1351 Rock. Pike Rockville, Md.		25a REC'D BY REGISTRAR DATE DEC 6 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17214

1 PLACE OF DEATH a COUNTY MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL) c LENGTH OF STAY IN 1b 7mo 13 days d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE MARYLAND b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d STREET ADDRESS 500 S Ann st. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ROBERT LEE FILAR		4 DATE OF DEATH 16 December 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Aug 1948
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Military	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
13. FATHER'S NAME ALFRED A. FILAR SR.		14. MOTHER'S MAIDEN NAME PERZYNSKI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 17 Nov. 66		16. SOCIAL SECURITY NO. 213-54-3784	
17. INFORMANT LILIAN JEAN FILAR		Address 500 S Ann St. Baltimore, Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myelogenous Leukemia Hemorrhage DUE TO (b) Chronic Myelogenous Leukemia DUE TO (c) 7Mo		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 3 May , 19 67 , to 16 Dec , 19 67 , that (I) (we) lost saw the deceased alive on 16 Dec 1967 , and that death occurred on 24 Dec 1967 , from causes and on the date stated above			
22a. SIGNATURE Charles S. Reeves		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles S. Reeves Lt MC USN		22d. ADDRESS NAVAL HOSPITAL BETHESDA, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12/20/67	23c NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore, Baltimore, Maryland
24. FUNERAL DIRECTOR Kaczrowski Funeral Home Baltimore, Md.		25a. REC'D BY REGISTRAR DEC 26 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

CERTIFICATE OF DEATH

17215

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		e. STREET ADDRESS 263 Congressional Ln	
3 NAME OF DECEASED (Type or print) Ruth F. Fischer		4 DATE OF DEATH Dec 19 1967	
5 SEX F	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/19/1889
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Kentucky		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Charles Farkusci		14 MOTHER'S MAIDEN NAME Mary M. Vetter	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO	
17 INFORMANT Mrs. Guy Smith		Address Same as Item 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 Myocardial Infarction IMMEDIATE CAUSE (a) DUE TO ASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 8 days 10 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Thrombosis			19 WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 1964 , to 12/19/1967 , that (I) (we) last saw the deceased alive on 12/19/1967 , and that death occurred at 11:00 M, from causes and on the date stated above			
22a SIGNATURE Robert C. Macon M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED 12/19/67
22c PHYSICIAN'S NAME (Type) ROBERT C. MACON		22d ADDRESS 809 Viers Mill Rd.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12-22-67	23c NAME OF CEMETERY OR CREMATORY Ft. Hill Mem. Park	23d LOCATION (City or Town) (County) (State) Lynchburg, Virginia
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a REC'D BY REGISTRAR DEC 26 1967	25b REGISTRAR'S SIGNATURE Charles J. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

CERTIFICATE OF DEATH

17216

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL) c. LENGTH OF STAY IN lb 19 DAYS		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY VIRGINIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICKSBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		d. STREET ADDRESS 1307 HANOVER ST. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ERNEST FONDREN		4. DATE OF DEATH Month DECEMBER Day 16 Year 1967	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 March 1893 9. AGE (in years last birthday) 74 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Justice of Peace		10b. KIND OF BUSINESS OR INDUSTRY Military	11 BIRTHPLACE (County & State, or foreign country) Marion, Alabama
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Henry J. Fondren	
14. MOTHER'S MAIDEN NAME Information not available		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 1912-1945	
16 SOCIAL SECURITY NO Not known		17. INFORMANT Mrs. Nannie L. Fondren Address 1307 Hanover St. Fredericksburg, Va.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Lung 163 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONITIS, DIFFUSE, BILATERAL		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 27 Nov., 1967 , to 16 Dec., 1967 , that (I) (we) last saw the deceased alive on 16 Dec., 1967 , and that death occurred at 955A M. from causes and on the date stated above.			
22a. SIGNATURE <i>E. Perlin</i>		22b. DATE SIGNED 16 Dec 1967	
22c. PHYSICIAN'S NAME (Type) E. Perlin, Lcdr MC USN		22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-18-67	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Fredericksburg Va.
24. FUNERAL DIRECTOR WHEELER AND THOMPSON		25a. REC'D BY REGISTRAR DEC 21 1967	
ADDRESS FREDERICKSBURG, VA.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17214

17217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>1 month</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>11106 Woodson Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>M.</u> Last <u>Marszke</u>		4 DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>England</u>	
13. FATHER'S NAME <u>Edward Jeffreys</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>No</u>	
17. INFORMANT <u>Mrs. Daphne Hill</u>		Address <u>11106 Woodson Avenue Kensington, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia due to Pyelonephritis</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Healed Myocardial Infarct</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>6 months</u> <u>6 months</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1967</u> to <u>Dec 7, 1967</u> that (I) (we) last saw the deceased alive on <u>Dec 7, 1967</u> and that death occurred at <u>5:30 A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>John J. Curry</u>		22b. DATE SIGNED <u>12/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry</u>		22d. ADDRESS <u>10620 Georgia Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 9, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. ADDRESS <u>434 Regia Avenue Silver Spring, Md.</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/6/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>41 Westwood Lane</u>	
3 NAME OF DECEASED (Type or print) <u>Anthony Fortier</u>		4 DATE OF DEATH Month <u>Dec</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 30, 1909</u>
9 AGE (In years last birthday) <u>58</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Operator</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTH-PLACE (State or foreign country) <u>New Hampshire U.S.A.</u>	
13 FATHER'S NAME <u>Joseph Fortier</u>		14 MOTHER'S MAIDEN NAME <u>Fauve Labrie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give year or dates of service) <u>yes 21 Aug 1943-17-1944</u>		16 SOCIAL SECURITY NO <u>043-17-1944</u>	
17 INFORMANT <u>Mr. Millie Cox</u>		Address <u>12 Pine</u>	
18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Recent & Remote</u> DUE TO (b) <u>Coronary arteriosclerosis with occlusion</u> DUE TO (c) <u>PO</u>			INTERVAL BETWEEN ONSET AND DEATH <u>26 MIN.</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Esophago-gastrostomy, post 5 days, for carcinoma esophagus</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the removal described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>Dec 12, 1967</u>	
EXAMINER'S NAME (Type) <u>John G. Ball Bethesda, Maryland</u>		Address (Street, city, town or county)	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24 FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>DEC 15 1967</u>	
ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

17219

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u></u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u></u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home 2325 Hampshire Ave.</u>		e STREET ADDRESS <u>3636 S. Street, N.W.</u>	
3 NAME OF DECEASED (Type or print) <u>CAROLINE FOSTER</u>		4 DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-27-82</u>
9 AGE (In years lost birthday) <u>85</u> yrs		10 IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Hiram G. Hotchkiss</u>		14 MOTHER'S MAIDEN NAME <u>Louise W. Knowles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u></u>	
17. INFORMANT <u>Mary L. Charles</u>		Address <u>3636 S St. NW Wash. DC</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized, Fracture of hip.</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>
20f (City or town) (County) (State) <u></u>		
21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>65</u> , to <u>12/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/9</u> , 19 <u>67</u> , and that death occurred at <u>5:15 PM</u> , from causes and on the date stated above		
22a SIGNATURE <u>Seymour Greenbaum</u>	M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED <u>12/9/67</u>
22c PHYSICIAN'S NAME (Type) <u>Seymour Greenbaum, M.D.</u> ADDRESS <u>1800 Eye St, N.W. Washington, D.C.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	23b DATE THEREOF <u>12/11/1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>
23d LOCATION (City or Town) (County) (State) <u>Suitland, Md</u>		
24 FUNERAL DIRECTOR <u>Joseph & Louis Sons</u>		25a REC'D BY REGISTRAR <u></u>
ADDRESS <u>5130 Wisconsin Ave. NW Washington, DC</u>		25b REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>
DATE <u>DEC 15 1967</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17222

Item #23c Film #396

CERTIFICATE OF DEATH

17220

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE South Carolina b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lyman	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS 8 Crest Street	
3. NAME OF DECEASED (Type or print) Mary Ruth Fowler		4. DATE OF DEATH December 17 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1915
9 AGE (In years last birthday) 52 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stitcher		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11 BIRTHPLACE (County & State, or foreign country) South Carolina		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Ray Powell		14 MOTHER'S MAIDEN NAME Mary A. Case	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. Not available	
17 INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			
PART I. DEATH WAS CAUSED BY.			
IMMEDIATE CAUSE (a) Pulmonary Aspergillosis			
DUE TO			
(b) Brain abscess			
DUE TO			
(c) Hodgkin's Disease post radiotherapy			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 16, 1967 , to Dec. 17, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 17, 1967 , and that death occurred at 11:00M , from causes and on the date stated above.			
22a. SIGNATURE F. C. Grumet MD		22b. DATE SIGNED 1967 17 December	
22c. PHYSICIAN'S NAME (Type) Frank C. Grumet, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE THEREOF Dec 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY Wood Mem. Park, Route 6		23d. LOCATION (City or Town) (County) (State) Greer, S. C. Spartanburg Co	
24. FUNERAL DIRECTOR Joseph Gawler's Sons 5130 Wisc. Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR DEC 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chevy Chase Nursing & Convalescent Center		d. STREET ADDRESS 2737 Devonshire Pl., N. W.	
3 NAME OF DECEASED (Type or print) First Middle Last RITA G. FRANK		4. DATE OF DEATH Month Day Year December 31 19 67	
5 SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1887
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) San Francisco, Calif.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Berthold Grunebaum		14. MOTHER'S MAIDEN NAME Nanette Blum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO unknown	
17. INFORMANT Mrs. B.C. Sanders		Address 2705 Navarre Drive Chevy Chase, Md. 20015	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho-Pneumonia 491X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subarachnoid Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 30 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 19 67 to 12/31 , 19 67 , that (I) (was) last saw the deceased alive on 12/3 , 19 67 , and that death occurred at 345P M, from causes and on the date stated above			
22a. SIGNATURE Samuel Dessoff M.D.		22b. DATE SIGNED 12/31/67	
22c. PHYSICIAN'S NAME (Type) SAMUEL DESSOFF		22d. ADDRESS 1302-18 ST-N.W. NWASH DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/4/68	23c. NAME OF CEMETERY OR CREMATORY Washington Hebrew Congregation	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Wash., D. C.		25a. REC'D BY REGISTRAR JAN 5 1968	25b. REGISTRAR'S SIGNATURE Charles J. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 9 Film 8396 1/5/68 W

CERTIFICATE OF DEATH

17222

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN lb <u>11 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>44th - Shuman Blvd</u>	
3 NAME OF DECEASED (Type or print) <u>William G. Franklin</u>		4 DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/6/31</u> <u>HA</u> In years <u>36</u> last birthday yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Suburban</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Suburban</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Florida</u>
13. FATHER'S NAME <u>Charles Simpson Franklin</u>		14. MOTHER'S MAIDEN NAME <u>Kirk Vickick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>261-367239</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>330x</u> IMMEDIATE CAUSE (a) DUE TO <u>Ruptured congenital aneurysm, right cerebellar artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-14</u> , 19 <u>67</u> , to <u>12-25</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>12/25/67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Francis C. Mayle Jr MD</u>		22b. DATE SIGNED <u>12/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS C. MAYLE JR MD</u>		22d. ADDRESS <u>8218 Wisconsin Ave Bethesda MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REG STRAR <u>DEC 29 1967</u> 25b. REGISTRAR'S SIGNATURE <u>no</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17225

17223

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 15	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1004 DeBeck Drive		d. STREET ADDRESS 1004 DeBeck Drive	
3 NAME OF DECEASED (Type or print) First Rose Middle Anne Last Frazier		4 DATE OF DEATH Month December Day 16 Year 1967	
5 SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 10, 1883
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 1 Days 15 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Benjamin Thomas		14. MOTHER'S MAIDEN NAME Mary Katherine Cooley	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Mary Phoebe - Niece - 541 Brent Road		Address Rockville, Md.	
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary atherosclerosis & myocardial infarction DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 5 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month Jan Day 15 Year 1967 Hour 10 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1966 , 19 to Dec 16 , 1967, that (I) (we) last saw the deceased alive on Dec 15 , 1967, and that death occurred approx A M, from causes and on the date stated above.			
22a. SIGNATURE W. A. Linticum		22b. DATE SIGNED 12/17/67	
22c. PHYSICIAN'S NAME (Type) W. A. Linticum, MD		22d. ADDRESS 1105 Washington St. Rockville, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 12/19/67	
23c. NAME OF CEMETERY OR CREMATORY Clarksburg Cemetery		23d. LOCATION (City or town) (County) (State) Clarksburg, Maryland	
24 FUNERAL DIRECTOR Tyson Wheeler		25a. REC'D BY REGISTRAR DEC 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

17226

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE Maryland b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium Hospital		d. STREET ADDRESS 402 Lexington Drive	
3. NAME OF DECEASED (Type or print) Marion Esther Frech		4. DATE OF DEATH December 21, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-9-90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NSW		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Washington D.C.
13. FATHER'S NAME Albertus Wilson		14. MOTHER'S MAIDEN NAME Cora	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no or unknown) NO		16. SOCIAL SECURITY NO 218-54-1	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute severe cerebral vascular accident SIX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDI- TION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 , 19 December 21, 1967 , that (I) (we) last saw the deceased alive on December 20, 1967 , and that death occurred at 2:30 A.M. from causes on and on the date stated above.			
22a. SIGNATURE Bennet A. Porter, Jr.		22b. DATE SIGNED December 21, 1967	
22c. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D.		22d. ADDRESS 9301 Coleville Rd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Dec. 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or town) (County) (State) Washington D.C.
25a. REC'D BY REGISTRAR Glen Porter		25b. REGISTRAR'S SIGNATURE Glen Porter	
DATE DEC 28 1967		J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

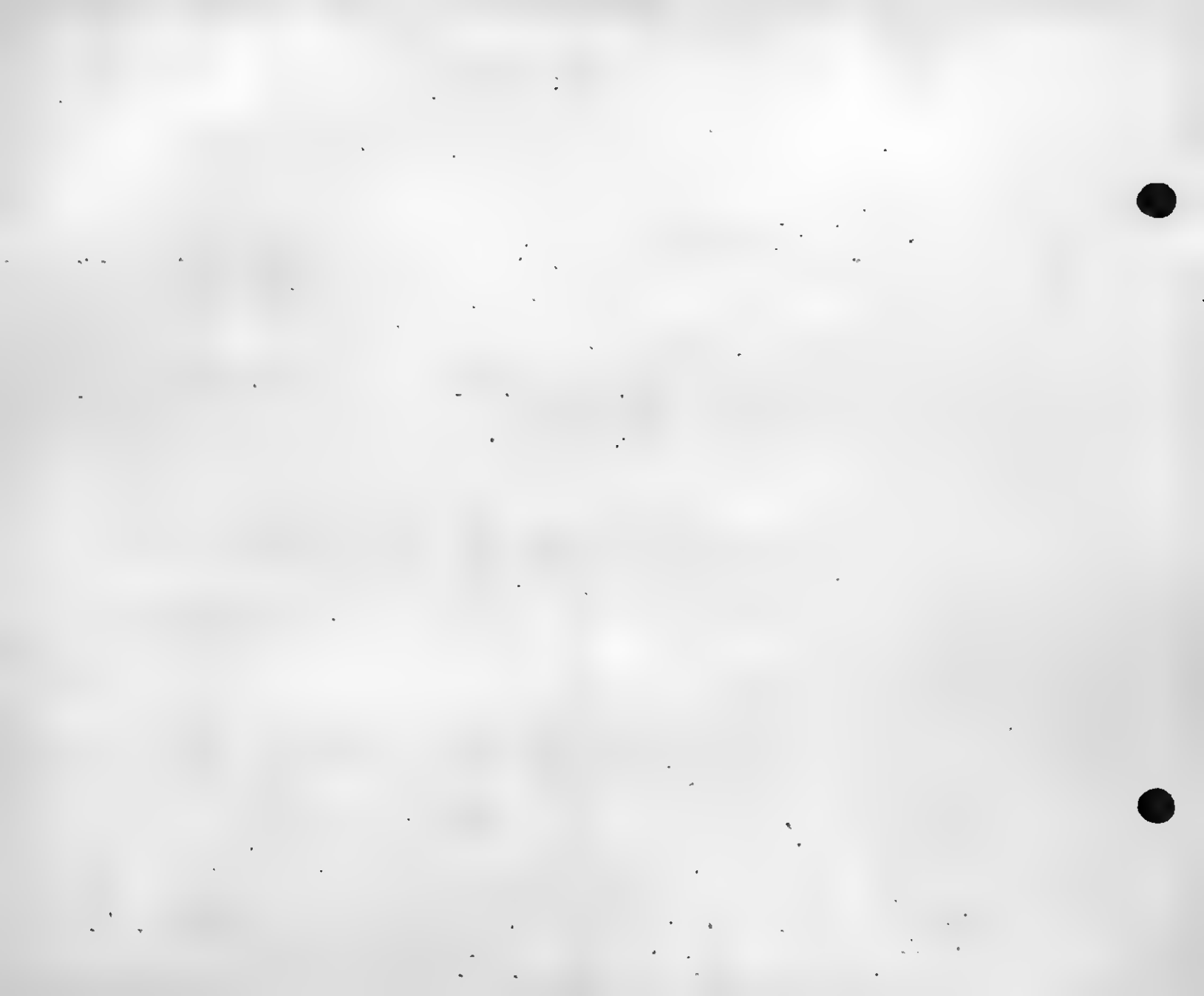
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Cleared 3 medical examiners

MEDICAL CERTIFICATION

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
KATE CLYDE FREEMAN					Month 12 Day 26 Year 67		8:00 PM	
3 SEX	7	4 RACE	Cauc		5 DATE OF BIRTH	6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			
ALABAMA		U. S. A.		MONTGOMERY				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
ALABAMA	UNIVERSITY NURSING		GENERAL OFFICE WORKER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
MD		MONTGOMERY	SILVER SPRING		8607 PINE / BRANCH			
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
HAYWOOD				CLENDENIN	CALLIE ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT				
		579-28-0439		J. Richard Conroy 8703 Address Wood Street				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular collapse								10 minutes
4. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease								years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
Iron deficiency anemia; cholelithiasis								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from March, 1967 to 12-26, 1967, that (I) (we) last saw the deceased alive on 12-7, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
JASON GEIGER, M.D.						12-26-67		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE				
JASON GEIGER, M.D.		800 PEARSON DRIVE SILVER SPRING, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
		Dec. 29, 1967		Fort Lincoln Cemetery		Prince Georges County, Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
LORRA J. GIBBS		11, Inc. Silver Spring, Md.		DATE JAN 10 1968				



CERTIFICATE OF DEATH

17226

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>10 1/2 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>5480 Wisc. Ave.</u> <u>Highland House</u>	
3. NAME OF DECEASED (Type or print) <u>IDA</u> First <u>FRIEDMAN</u> Middle <u>EREDMAN</u> Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/1909</u> 58 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zachary ABRAMOWITZ</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Epstein</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>27 Dec, 1967</u> to <u>28 Dec, 1967</u> , that (I) (we) last saw the deceased alive on <u>27 Dec, 1967</u> , and that death occurred at <u>8:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Horace W. Bernton</u> M.D.		22b. DATE SIGNED <u>12/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Horace W. Bernton</u>		22d. ADDRESS <u>4743 Bradley Blvd. Ch. Ch. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-29-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden</u>	23d. LOCATION (City or town) (County) (State) <u>Falls Church Virginia</u>
24. FUNERAL DIRECTOR <u>B. Benjamins & Son</u>		25a. REC'D BY REGISTRAR <u>3501-1420</u> DATE <u>JAN 2 1968</u>	
25b. REGISTRAR'S SIGNATURE			

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17227

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN It		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3. NAME OF DECEASED (Type or print) <u>Andrew' Edmund' Friedrich</u> First Middle Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-5-15</u> 9. AGE (In years last birthday) <u>52</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drugs</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Penna</u>
13. FATHER'S NAME <u>Andrew Friedrich</u>		14. MOTHER'S MAIDEN NAME <u>Rudra</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>4-11-11-11</u>	
17. INFORMANT <u>Janetta Friedrich w/o</u>		Address <u>add same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> DUE TO (b) <u>myocardial infarct, recent</u> DUE TO (c) <u>Coronary atherosclerosis</u> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>67</u> , to <u>Dec 23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 23</u> , 19 <u>67</u> , and that death occurred at <u>6:00 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>George H. Mitchell</u>		22b. DATE SIGNED <u>12/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE H. MITCHELL, M.D.</u>		22d. ADDRESS <u>11125 ROCKVILLE PIKE, ROCKVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Balt National Ceme</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>Delwitt Klannedon Laurel Md</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 3 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>T. J. [Signature]</u>	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17228

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring (Hillendale)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa 12325 New Hope Ave</u>		d. STREET ADDRESS <u>1616 Oaklawn Court</u>	
3. NAME OF DECEASED (Type or print) <u>Carrie FRENCH Froehlich</u>		4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh-</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-186</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Agriculture</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lucius French</u>		14. MOTHER'S MAIDEN NAME <u>Anna (unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-44-6843</u>	
17. INFORMANT <u>Hillendale Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u></u> (c) <u></u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>NOV 2</u> , 19 <u>67</u> , to <u>12/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>DEC 19</u> , 19 <u>67</u> , and that death occurred at <u>10:40 A.M.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>B. G. Bendler</u>		22b. DATE SIGNED <u>12/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B.G. Bendler</u>		22d. ADDRESS <u>10820 Ga. Avenue, Wheaton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVA, (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 2, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter 8434</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc. Silver Spring, Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		DATE <u>JAN 8 1968</u>	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b Rockville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11313 Old Club Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 11313 Old Club Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cecil Forest Frost		4. DATE OF DEATH Month December Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/05
9. AGE (In years last birthday) 62		10. IF UNDER 1 YEAR Months 13 Days 13	11. IF UNDER 24 HRS. Hours 13 Min 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Texas	
11. BIRTHPLACE (County & State, or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cecil R. Frost		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 532-09-7948	
17. INFORMANT Cecil R. Frost-son same item # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 25 , 19 67 , to 12-21 , 19 67 , that (I) (we) last saw the deceased alive on 12-8 , 19 67 , and that death occurred at 6:30 p.m. from causes and on the date stated above			
22a. SIGNATURE Alfred S. Norton		22b. DATE SIGNED 12/22/67	
22c. PHYSICIAN'S NAME (Type) Alfred S. Norton, M.D.		22d. ADDRESS 7710 Dwight Drive, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/67	
23c. NAME OF CEMETERY OR CREMATORY Woodland Cemetery		23d. LOCATION (City or Town) (County) (State) Woodland Yolo Calif.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25. REC'D BY REGISTRAR DEC 28 1967	
26. REGISTRAR'S SIGNATURE Tyson Wheeler		27. REGISTRAR'S SIGNATURE Tyson Wheeler	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17230

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution on, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>5907 Rolston Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>BARLETT</u> Last <u>Fuchs</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/08</u>
9 AGE (In years lost birthday) <u>59</u> yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Counselor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>District School System Wash. D.C.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William Robert Fuchs</u>		14. MOTHER'S MAIDEN NAME <u>Georgia Barrett</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Same as Item 2.</u>	
17 INFORMANT <u>Wife</u> <u>Anne Pyle Fuchs</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive right intracerebral hemorrhage, spontaneous</u> DUE TO (b) <u>Rupture of right middle cerebral artery</u> Cerebral arteriosclerosis & Hypertensive heart disease (c) <u>Cerebral arteriosclerosis & Hypertensive heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>62</u> , to <u>Dec 25</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>Dec 24</u> , 19 <u>67</u> , and that death occurred at <u>1:55</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred S. Norton</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>12-25-67</u>
22c. PHYSICIAN'S NAME (Type) <u>ALFRED S. NORTON</u>		22d ADDRESS <u>7710 Dwight Drive Bethesda, Maryland</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12-28-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 29 1967</u>	25b. REGISTRAR'S SIGNATURE <u>and by J. J. J.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>NEW JERSEY</u> b. COUNTY <u>Pitman</u>	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pitman</u>	
c. LENGTH OF STAY IN TB <u>3 days</u>		d. STREET ADDRESS <u>57 Colonial Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDWARD ROY GARLAND</u>		4. DATE OF DEATH <u>December 5, 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1985</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEWHA R.R.</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Altoona, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>YES</u>	
17. INFORMANT <u>Mrs. Jeanette Garland</u>		Address <u>57 Colonial Ave. Pitman, New Jersey</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Pulmonary edema</u> DUE TO (c) <u>Myocardial infarct</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour : o m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> , 19 <u>67</u> , to <u>12/5</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>12/4</u> , 19 <u>67</u> , and that death occurred at <u>1:35 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Richard Delaney</u>		22b. DATE SIGNED <u>12/5/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard Delaney</u>		22d. ADDRESS <u>4323 Harvard St., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>Dec. 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington Twp., New Jersey</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 11 1967</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY in 1b 21 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOLY CROSS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 9933 MOSS AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GWENDOLINE GEACH		4. DATE OF DEATH DEC. 28 1967	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/95
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GOVT.		10b. KIND OF BUSINESS OR INDUSTRY Labor Consultant	
11. BIRTHPLACE (County & State, or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Geach		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Norine Diamond Silver Spring, Md.		18. ADDRESS 521 Dantz Dr. Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous invasion of liver Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Primary Carcinoma of Stomach OUE TO (c) Illness INTERVAL BETWEEN ONSET AND DEATH approx 6 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 7, 1967 to Dec 28, 1967 , that (I) (we) last saw the deceased alive on Dec 27, 1967 , and that death occurred at 6:10 AM , from the causes and on the date stated above.			
22a. SIGNATURE Gene U. Cohen M.D.		22b. DATE SIGNED Dec 28 67	
22c. PHYSICIAN'S NAME (Type) GENE U. COHEN M.D.		22d. ADDRESS 1106 SPRING ST SILVER SPRING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Dec 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City, town or county) (State) Prince Georges Co. Md.
24. FUNERAL DIRECTOR James S. Monahan		25a. REC'D BY REGISTRAR J. J. 2 1968	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laytonsville</u>	
c. LENGTH OF STAY IN 1b <u>15 mths.</u>		d. STREET ADDRESS <u>Suburban</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Augustus Thomas Gibson</u>		4 DATE OF DEATH Month <u>Dec.</u> Day <u>5</u> Year <u>1947</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years, last birthday) <u>40</u> yrs
9 IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>47</u>		10 IF UNDER 24 HRS Months <u>5</u> Days <u>19</u> Hours <u>47</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver Maryland</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Capt.</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Augustus Thomas Gibson, Sr.</u>		14 MOTHER'S MAIDEN NAME <u>Beatrice Gibson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO <u>578-36-2999</u>	
17 INFORMANT <u>Charlotte Gibson</u>		18 ADDRESS <u>As above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>MI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>MI</u>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>MI</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/5/47</u>	
		Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>	23d. LOCATION (City or Town) (County) (State) <u>Laytonsville, Mont. Md.</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		25a. REC'D BY REG. STRAR DATE <u>DEC 7 1967</u>	
ADDRESS <u>Laytonsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be attached for use as the burial-transit permit. Then please remove carryover pages 2 and 3 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MONTGOMERY COUNTY, MARYLAND											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
Items 13 & 14 Film G396 1/12/68											
CERTIFICATE OF DEATH											
17234											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN lb 12 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5304 Flanders Ave.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 5304 Flanders Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First ANGELO Middle G. Last GOFFREDO						4. DATE OF DEATH Month Dec. Day 21 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1887		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Merchant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Bari, Italy			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Unknown Felice Goffredo						14. MOTHER'S MAIDEN NAME Unknown Angelina Montabana					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 233-54-6723		17. INFORMANT Daughter Angelina Goffredo			Address Same as Item 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Acute congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① Pneumophagus vulgaris ② Carcinoma of bladder										INTERVAL BETWEEN ONSET AND DEATH 4 hours 10 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? - YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1958, 19 to Dec 21, 1967 , that (I) (we) last saw the deceased alive on Dec 21, 1967 , and that death occurred at 1 PM , from the causes and on the date stated above.											
22a. SIGNATURE Robert N. Coale						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) ROBERT N. COALE						22d. ADDRESS 4429 Bradley Lane Chevy Chase Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-23-67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.			23d. LOCATION (City, town or county) (State) Silver Spring, Md.		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.						25a. REC'D BY REGISTRAR DEC 29 1967		25b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

17235

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		d. STREET ADDRESS 6000 Norman Avenue	
3. NAME OF DECEASED (Type or print) William Samuel Goodman		4. DATE OF DEATH Month December Day 30 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-5-03
9. AGE (In years last birthday) 64 yrs		10. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Forman	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? America U.S.	
13. FATHER'S NAME Samuel W. Goodman		14. MOTHER'S MAIDEN NAME Mary Moon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 578 10 7813	
17. INFORMANT Patient's chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Congestive heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, Pulmonary Emboli Suspected			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (F EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part I. of item 18)	
20c. TIME OF INJURY Month, Day Year Hour, min. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 , to Dec 30 19 67 , that (I) (we) last saw the deceased alive on Dec 29 19 67 , and that death occurred at 2 A M, from causes and on the date stated above			
22a. SIGNATURE Robert B. Cresh		22b. DATE SIGNED 12-30-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/2/68	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR JAN 4 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17236

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN lb <u>12 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e STREET ADDRESS <u>10100 Montgomery Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Frederic S Granger</u>		4 DATE OF DEATH <u>Dec 28 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 31, 1884</u>
9 AGE (In years last birthday) <u>83</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Walter L Granger</u>	
14 MOTHER'S MAIDEN NAME <u>Katherine Bullman</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16 SOCIAL SECURITY NO		17 INFORMANT Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>465x Infarctions, pulmonary, bilateral</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>12-27</u> , 19 <u>67</u> , to <u>12-28</u> , 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>12-28</u> 19 <u>67</u> , and that death occurred at <u>10:59</u> AM, from causes and on the date stated above			
22a SIGNATURE <u>J Thornton Boswell, M.D.</u>		22b DATE SIGNED <u>12-28-67</u>	
22c PHYSICIAN'S NAME (Type) <u>J Thornton Boswell, M.D.</u>		22d ADDRESS <u>8600 OLD GEORGETOWN RD BETHESDA, MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Dec. 30, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Brainard Cemetery</u>	23d LOCATED ON (City or Town) (County) (State) <u>Cranberry, New Jersey</u>
24 FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY BETHESDA, MD.</u>		25a REC'D BY REGISTRAR <u>JAN 5 1968</u>	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1, 2, 3) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17236

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 1 Yr. 7 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10500 Rockville Pike		d. STREET ADDRESS 10500 Rockville Pike	
3 NAME OF DECEASED (Type or print) WILLIAM D. GRIFFITH		4. DATE OF DEATH Month 12 Day 10 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 25, 1893
9. AGE (In years last birthday) yrs 74		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto-dealer		10b KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Earl Griffith		14 MOTHER'S MAIDEN NAME Elizabeth Jones	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 577-03-5858	
17. INFORMANT wife Mary F. Griffith		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO (b) Coronary thrombosis DUE TO (c) Coronary atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 15 min 15-20 " Unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED Whole <input type="checkbox"/> Not Whole <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1946 to present, 1967 , that (I) (we) last saw the deceased alive on Dec 7 1967 , and that death occurred at 10:30 P M , from causes and on the date stated above.			
22a SIGNATURE Francis J. Murray 22c PHYSICIAN'S NAME (Type) FRANCIS J. MURRAY		22b. DATE SIGNED 12-11-67	
22d ADDRESS 1601 - 18th Street, N. W. Washington, D. C.		22e. REC'D BY REGISTRAR DATE DEC 15 1967	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12-13-67	
23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George County, Md	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

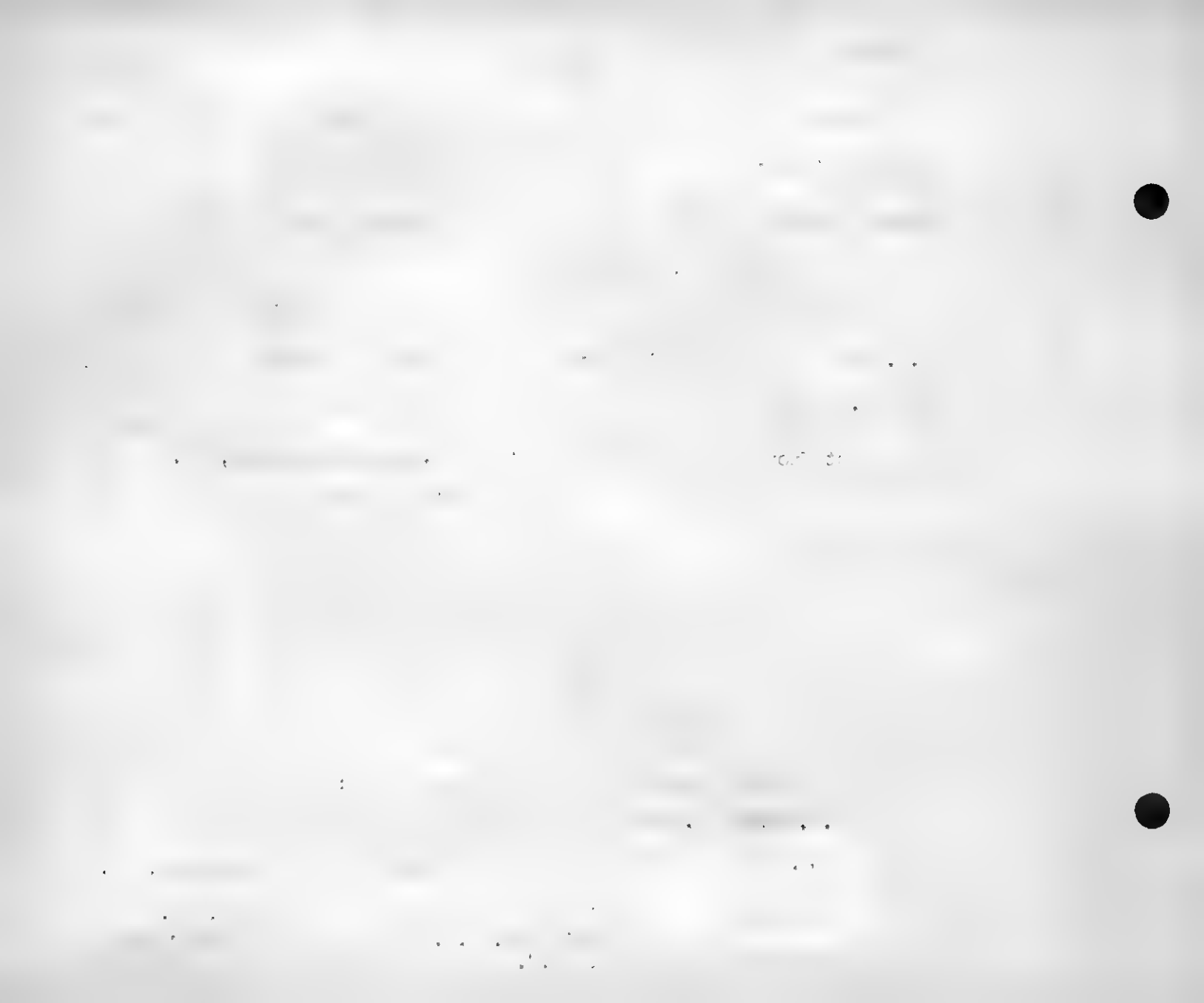
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17239

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 5 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Medical		d. STREET ADDRESS 4858 Battery Lane	
3 NAME OF DECEASED (Type or print) James D. HALSEY		4 DATE OF DEATH Month 12 Day 27 Year 19 67	
5 SEX Male	6. COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12 June 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Military	
11 BIRTHPLACE (County & State or foreign country) Huntsville, Alabama		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert S. Halsey		14. MOTHER'S MAIDEN NAME Lucy Landmann	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes Not Known		16 SOCIAL SECURITY NO 214 26 3521	
17 INFORMANT Martha T. Halsey Bethesda, Md.		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Atherosclerosis, Severe DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 23 DEC 1967 to 27 DEC 1967 , that (I) (we) last saw the deceased alive on 27 December 1967 , and that death occurred at 6:15 PM from causes on and on the date stated above.			
22a. SIGNATURE E. PERLIN		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. SODE		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	23b. DATE THEREOF Dec 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24 FUNERAL DIRECTOR Joseph Gawler & sons		25. REC'D BY REGISTRAR DATE 3 1968	

REGISTRAR'S SIGNATURE
John A. Judge



CERTIFICATE OF DEATH

17241

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN TB <u>9 YRS.</u>		d. STREET ADDRESS <u>9009 Woodland Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WHEATON NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LYDIA F. Miller</u> <u>Hamilton</u>		4. DATE OF DEATH <u>DEC. 26</u> 19 <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 14, 1870</u> 9. AGE (In years last birthday) <u>97</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry MILLER</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>ANNE M. GARNER</u> Address <u>ROCKVILLE 4100 SOUTHWIND RD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> 2 YRS stating the underlying cause last. (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/7</u> , 19 <u>65</u> , to <u>26 DEC</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>26 DEC</u> 19 <u>67</u> , and that death occurred at <u>1145</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Walter Gooch</u> M.D.		22b. DATE SIGNED <u>12/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER GOOCH MD</u>		22d. ADDRESS <u>2309 SHOREFIELD RD WHEATON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. J. Liebner Son</u>		25a. REC'D BY REGISTRAR <u>Jan 3 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Robert J. Burremud
4
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

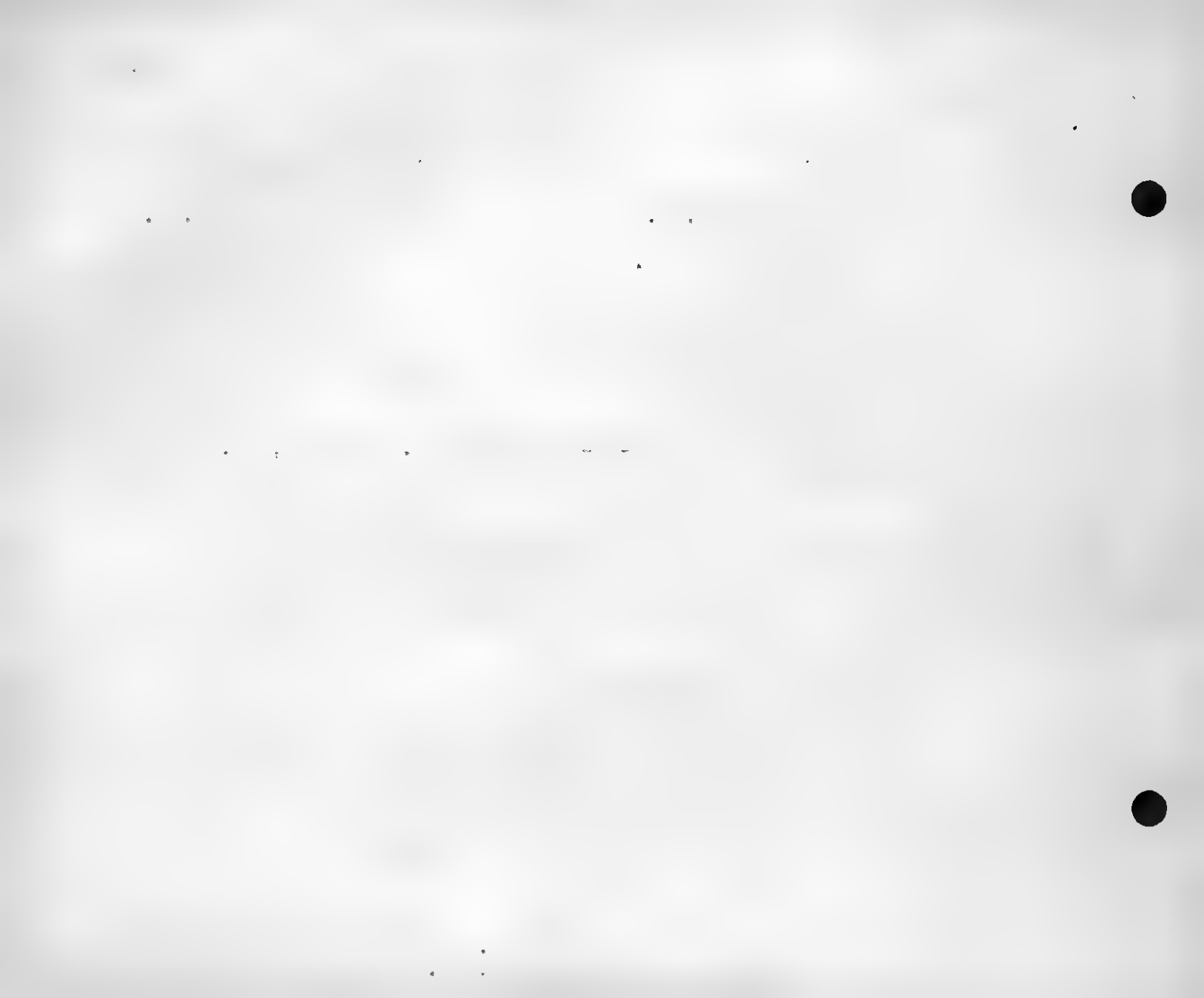
1242

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17241

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 420 University Blvd. W.		d. STREET ADDRESS 420 University Blvd. W.	
3 NAME OF DECEASED (Type or print) Helen A. Hamilton		4. DATE OF DEATH Month December Day 16 Year 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/04
9. AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR Months 1 Days 13 Hours Min 	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Charles Lechliger		14. MOTHER'S MAIDEN NAME Kelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 212-24-3993	
17 INFORMANT James A. Hamilton, Sr.		Address # 2 Husband same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial infarction DUE TO coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Relative hyperlipidemia		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/17, 1967 to 12/11, 1967 , that (I) (we) last saw the deceased alive on 12/11 1967 , and that death occurred at 2 P.M. from causes and on the date stated above.			
22a. SIGNATURE Arthur J. Willets		22b DATE SIGNED 12/11/67	
22c PHYSICIAN'S NAME (Type) ARTHUR J. WILLETS		22d ADDRESS 111 Spring St., Silver Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12/20/67	23c NAME OF CEMETERY OR CREMATORY Parklawn	23d LOCATION (City or Town) (County) (State) Rockville Montgomery Md
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a REC'D BY REGISTRAR 1331 Rock. Pike Rockville, Md.	
25b REGISTRAR'S SIGNATURE Richard J. Judge		DATE DEC 21 1967	



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VR A15 (4)
25M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 14 days/18 hrs.		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
3 NAME OF DECEASED (Type or print) Ralph Johnson Harden First Middle Last		4. DATE OF DEATH December 11, 1967 Month Day Year	
5. SEX Male	6. COLOR OF RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-95 AGE (In years birthday) 72 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. District Governor		10b. KIND OF BUSINESS OR INDUSTRY Ret. Foreman	
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Harden		14. MOTHER'S MAIDEN NAME Jane R. Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO 578-32-4466	
17. INFORMANT Hospital Records Address 7600 Carroll Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 181.0 Metastatic CA of bladder DUE TO (b) Carcinoma of bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-10-67 , 19 67 , to 12-11-67 , that (I) (we) last saw the deceased alive on 12-10-67 , and that death occurred at 7:14 M, from causes and on the date stated above			
22a. SIGNATURE Gilbert B. Cusack M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 12-11-67	
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12/14/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Wash., D.C.
24. FUNERAL DIRECTOR Nailey's Funeral Home Inc.		25a. DEC. BY REGISTRAR DEC 18 1967 DATE	
		25b. REGISTRAR'S SIGNATURE James Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 7 & 16 Film G496 1/11/68 kk

CERTIFICATE OF DEATH

17243

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>24 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Cherry Chase Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Greene</u> Last <u>Have</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/5/11</u>
9. AGE (In years last birthday) <u>56</u> YES		IF UNDER 1 YEAR Months Days Hours Min. <u>23</u> <u>1967</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Puffell Charles</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Years Rockwell</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Fichtelberg</u>		14. MOTHER'S M.A.D.N. NAME <u>Margaret Love May</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of serv.)		16. SOCIAL SECURITY NO <u>220-26-7165</u>	
17. INFORMANT <u>Jacob Levine Fitch</u> Address <u>355 5th St</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> DUE TO <u>nutritional cirrhosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>nutritional cirrhosis</u> (c) <u>nutritional cirrhosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Vagina</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>49</u> to <u>Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>DEC 23 1967</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>DR Leo I. Brown MD</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR Leo I. Brown MD</u>		22d. ADDRESS <u>8218 Wisconsin Ave Bethesda</u>	
23a. BURIAL OR CREMATION <u>Burial</u>	23b. DATE THEREOF <u>12/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	23d. LOCATION (City or Town) (County) (State) <u>N. Tonawanda New York</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> Funeral Home <u>Rockville</u>		25. REC'D BY REGISTRAR <u>Pike</u> DATE <u>DEC 29 1967</u>	
26. REGISTRAR'S SIGNATURE <u>J. J. Judge</u>			

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>5714 Crawford Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louisa H Harmon</u>		4. DATE OF DEATH Month Day Year <u>Dec. 30 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-78</u>
9. AGE (In years last birthday) <u>92 89 yrs</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Berlin Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>225-05-4630</u>	
17. INFORMANT <u>Daughter - L. Smith</u>		18. <u>5400 Tuscarawa Rd. Wash, D. C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>central thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7d</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>coronary artery disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>12-30, 1967</u> , that (I) (we) last saw the deceased alive on <u>12-29 1967</u> , and that death occurred at <u>5:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>D.L. Bucy</u>		22b. DATE SIGNED <u>12-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D.L. Bucy</u>		22d. ADDRESS <u>809 Veas Mill Rd Rockville Md</u>	
23a. BURIAL, CREMATION, <u>Burial</u>	23b. DATE THEREOF <u>Jan 2 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Rockville, Mont. Md</u>
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>		25a. REC'D BY REGISTRAR <u>JAN 5 1968</u>	
ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17245

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		d. STREET ADDRESS <u>229 Grant Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith Senora Harper</u>		4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1920</u>
9. AGE (In years last birthday) <u>47 yrs</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Clinton J. Pomeroy</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Crump</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Patient's chart</u>		Address <u> </u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Perforated gastric ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 weeks</u> <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) (County) (State) <u> </u>		20g. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 25th, 1967</u> to <u>Dec 10, 1967</u> that (I) (we) last saw the deceased alive on <u>Dec 10, 1967</u> , and that death occurred at <u>12:44 AM</u> , from causes and on the date stated above.		
22a. SIGNATURE <u>Lyle Williams</u> M.D.		22b. DATE SIGNED <u>Dec 10th 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>Lyle Williams</u>		22d. ADDRESS <u>831 University Blvd E. Silver Spring</u>
23a. BURIAL, CREMATION, REMOVAL, SPECIALLY <u>Burial</u>	23b. DATE THEREOF <u>Dec 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>
23d. LOCATION (City or Town) (County) (State) <u>Calmar Manor</u> <u>MD</u>		23e. REC'D BY REGISTRAR <u>Arthur Walters, 254 Carroll Pl NW. DC</u>
24. FUNERAL DIRECTOR <u>Arthur Walters, 254 Carroll Pl NW. DC</u>		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17246

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SANITARIUM & HOSPITAL</u>		d. STREET ADDRESS <u>3700 Dupont Ave</u>	
3 NAME OF DECEASED (Type or print) <u>JACK William HARVILLE</u>		4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-00</u>
9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROOF READER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government</u>	
11 BIRTHPLACE (County & State or foreign country) <u>GA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACK HARVILLE</u>		14. MOTHER'S MAIDEN NAME <u>CAROLYN BELLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NAVY WWI</u>		16 SOCIAL SECURITY NO. <u>578-10-2167</u>	
17 INFORMANT <u>Carrie Harville</u> Address <u>3700 Dupont Ave. Kensington, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock due to</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Rupture of abdominal aortic aneurysm</u> DUE TO (c) <u>Severe aortic atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24</u> hrs <u>0</u> days <u>0</u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>66</u> to <u>present</u> , that (I) (we) last saw the deceased alive on <u>12/5</u> 19 <u>67</u> , and that death occurred at <u>6:35</u> PM, from causes and on the date stated above			
22a. SIGNATURE <u>John B. Umhau</u>		22b. DATE SIGNED <u>12/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU</u>		22d. ADDRESS <u>8803 Conn. Ave. Chevy Chase Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Asheville, North Carolina</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles J. Judd</u>	
25b. ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25c. DATE <u>DEC 13 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Nov 1

17243
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7
MONTGOMERY
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17247

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9217 Shelton St.		d. STREET ADDRESS Weston	
3 NAME OF DECEASED (Type or print) Frank First Middle Last		4 DATE OF DEATH Dec. 23 Month Day Year	
5 SEX Male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1886 9 AGE (In years last birthday) yrs 81
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY glass worker	
11 BIRTHPLACE (County & State, or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Frank H. McCurdy		Address Bethesda, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 15 MIN.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Dec. 22, 1967 , to Dec 23, 1967 , that (I) (we) last saw the deceased alive on Dec. 23, 1967 , and that death occurred at 8:50 AM , from causes and on the date stated above.			
22a SIGNATURE Leo M. Curtis		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED 12-23-67
22c. PHYSICIAN'S NAME (Type) Dr. Leo M. Curtis		22d ADDRESS 8218 WISCONSIN AVE., BETHESDA, MD.	
23a BURIAL, CREMATION, REMOVA. (Specify) Burial	23b DATE THEREOF 12-28-67	23c NAME OF CEMETERY OR CREMATORY Heavener Cemetery	23d LOCAT ON (City or town) (County) (State) Buckhannon, W. Va.
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS BETHESDA, MARYLAND	25a REC'D BY REGISTRAR JAN 5 1968
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4-75)
25M 1/67

MONTGOMERY COUNTY, MARYLAND				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
2249				CERTIFICATE OF DEATH			
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN b. <u>2</u> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		d. STREET ADDRESS <u>11016 Franklin St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4016 Franklin St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>JAMES CLANTON HAYNES</u>				4 DATE OF DEATH Month Day Year <u>Dec 31 1967</u>			
5 SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14 1909</u>	
9. AGE (in years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11 BIRTHPLACE (Country & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Clanton Haynes Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Flaye Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>216 40 5109</u>		17. INFORMANT <u>William Dulin 5612 Grove St Ch, Ch,</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Generalized metastatic Cancer to bone</u> 177X DUE TO (b) <u>Primary Adenocarcinoma of</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>the Prostate</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>2 1/3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 to <u>Dec 31</u> , 19 <u>67</u> , that (i) (we) last saw the deceased alive on <u>Dec 28 1967</u> , and that death occurred at <u>8:15 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Edward W. Nicklas</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD W. NICKLAS</u>				22d. ADDRESS <u>4830 - V St. N.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3 Jan. 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Mt Rainer Pr. Geo Md</u>	
24. FUNERAL DIRECTOR <u>Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 5 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

17249

1 PLACE OF DEATH a. COUNTY MONTGOM. KY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b DOA		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital of Silver Spring		d. STREET ADDRESS 4106 Dayhill Road	
3 NAME OF DECEASED (Type or print) Joseph		4 DATE OF DEATH Month 12 Day 25 Year 1967	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/06
9 AGE (In years, last birthday) 61		IF UNDER 1 YEAR Months 12 Days 25 Hours 15 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Helper		10b. KIND OF BUSINESS OR INDUSTRY Machine shop	
11 BIRTHPLACE (County & State, or foreign country) Baltimore Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Howard Joseph		14. MOTHER'S MAIDEN NAME Carrie Ellen Beall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO 579-03-2537	
17. INFORMANT wife Claire		Address 4106 Dayhill Rd. SSMd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) minutes DUE TO (c) minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Emphysema, Influenza, ARTERIOSCLEROTIC HEART Disease			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 1967, to Dec 25, 1967 , that (I) (we) last saw the deceased alive on 12/21 1967, and that death occurred at 9:00pm , from causes and on the date stated above			
22a. SIGNATURE Raymond T. Benack		22b. DATE SIGNED 12/25/67	
22c. PHYSICIAN'S NAME (Type) Raymond T. Benack MD		22d. ADDRESS 4115 Colie Drive, Wheaton MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-28-67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George County, Md.	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 29 1967	
		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION
Cleared with Medical Examiner R. B. Reap

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17250

1. PLACE OF DEATH a. COUNTY Montgomery County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 1-1/2 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 3412 Newton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gertrude Hernandez		4. DATE OF DEATH Dec. 4, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/17
9. AGE (in years, lost birthday) yrs 50		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Beautician	
11. BIRTHPLACE (County & State, or foreign country) Saltsville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Cahill		14. MOTHER'S MAIDEN NAME Florence	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 226 10 0085	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1602 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (b) ANEMIA - DEHYDRATION (c) CARCINOMATOSIS CARCINOMA @ MAXILLARY SINUS 6 months		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1955 , 19____, to Dec. 4, 1967 that (I) (we) saw the deceased alive on Dec. 4, 1967 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Benjamin L. Miller		22b. DATE SIGNED Dec 5, 1967	
22c. PHYSICIAN'S NAME (Type) Benjamin Miller, M. D.		22d. ADDRESS 3824 34th St., Mt. Rainier, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-7-1967	23c. NAME OF CEMETERY OR CREMATORY Elizabeth Cemetery	23d. LOCATION (City or Town) (County) (State) Saltsville, Virginia
24. FUNERAL DIRECTOR Valley Funeral Home Mt Rainier, Md.		25a. REC'D BY REGISTRAR DEC 7 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17251

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington, D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Althea Woodland Nsg. Home</i>		e. STREET ADDRESS <i>2832 28th St. N.W.</i>	
3. NAME OF DECEASED (Type or print) First <i>Edna</i> Middle <i>E.</i> Last <i>HICKER</i>		4. DATE OF DEATH Month <i>12</i> Day <i>28</i> Year <i>1967</i>	
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-21-1882</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
10. FATHER'S NAME <i>Elisha E. Berry</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
12. MOTHER'S MAIDEN NAME <i>Edna Eork</i>		13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>(No)</i>		15. SOCIAL SECURITY NO. <i>579-60-1365</i>	
16. INFORMANT <i>B. Greenley</i>		Address <i>811 Houston Takoma Park, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic vascular disease</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i> <i>5 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>—</i> p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>July 15, 1967</i> , to <i>Dec 28, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 21, 1967</i> , and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F. McElhannon</i>		22b. DATE SIGNED <i>12-28-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Thomas F. McElhannon</i>		22d. ADDRESS <i>3000 Conna. Ave. Wash DC.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE THEREOF <i>12/30/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Columbia Gardens Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Arlington, Va.</i>
24. FUNERAL DIRECTOR <i>The J.B. Hines Co. 2901 14th St. N.W.</i>		25a. REC'D BY REGISTRAR <i>JAN 3 1968</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

2 2 2
2 2 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

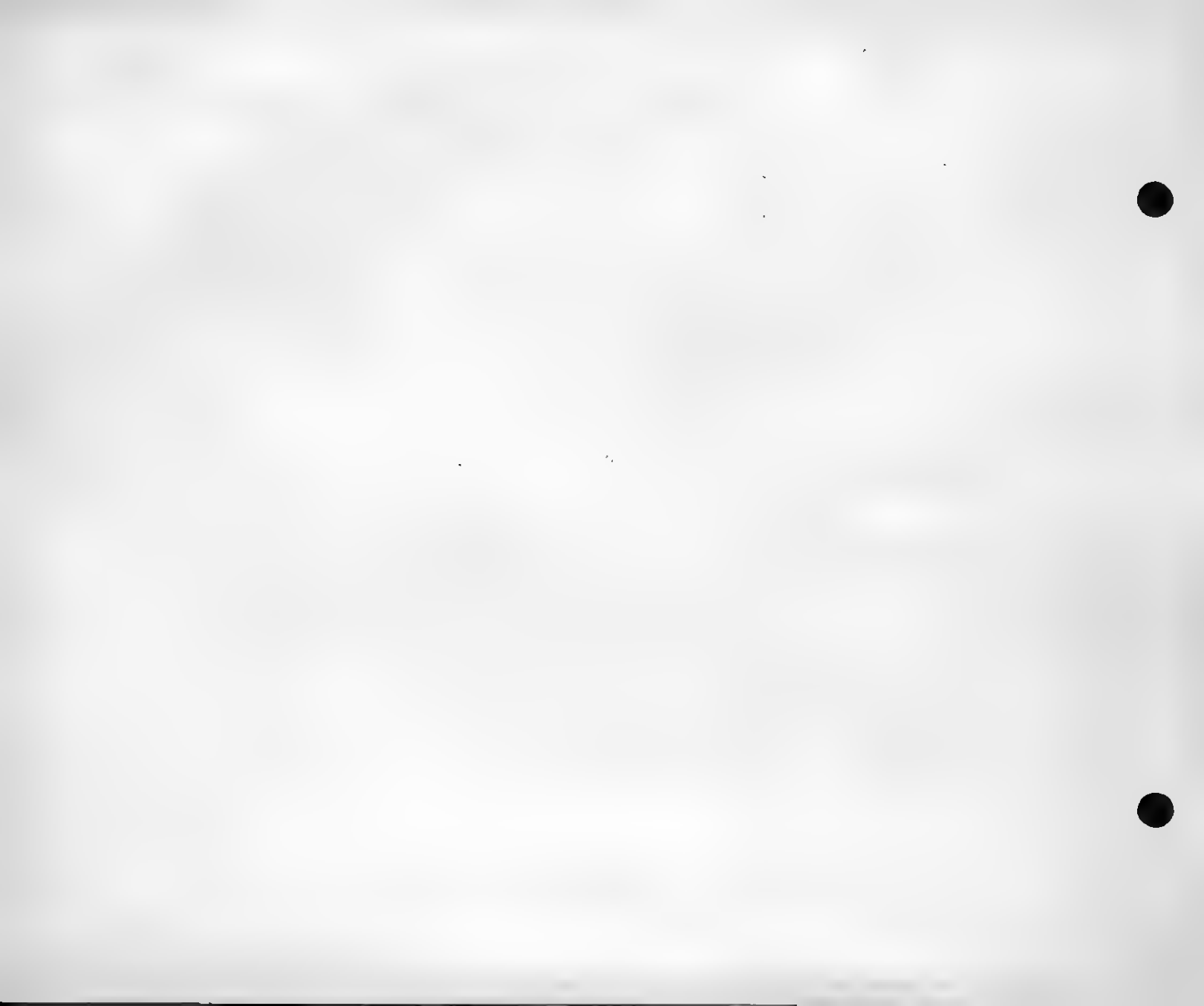
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery County</u> <u>FAIRLAND NURSING HOME</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONT.</u> <u>12008 CENTERHILL RD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON, MD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WHA-2171 Guilford Rd Sil. Spr., Md.</u>		d STREET ADDRESS <u>12008 Centerhill Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>K.</u> Last <u>HICKS</u>		4 DATE OF DEATH Month <u>Dec</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>F</u>	6 COLOR OR RACE <u>CAUC</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>15 JUNE 1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>STATISTICIAN (RETIRED) TREASURY DEPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHGO</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>CHGO</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DEAN KIEFER</u>		14 MOTHER'S MAIDEN NAME <u>ORDELIA PRATT</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> <u>NONE</u>		16 SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT Address <u>WARREN D. HICKS - SAME AS 2A-B-C-D</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (11) (this hospital) attended the deceased from <u>8-20-65</u> , 19 <u>65</u> , to <u>12-4</u> , 19 <u>67</u> , that (11) (we) last saw the deceased alive on <u>12-4-67</u> 19 <u>67</u> , and that death occurred at <u>3:37</u> P.M. from causes and on the date stated above			
22a. SIGNATURE <u>Morris Perry</u>		22b. DATE SIGNED <u>12-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRIS PERRY</u>		22d. ADDRESS <u>11602 GEORGIA AVE, SILVER SPRING, MD</u>	
23a. BURIAL, CREMATION, or other disposal <u>BURIAL</u>	23b. DATE THEREOF <u>12/7/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOUNTAIN MEMO. CO.</u>	23d. LOCATION (City or Town) (County) (State) <u>FOSTORIA, OHIO</u>
24 FUNERAL DIRECTOR <u>W.W. CHAMBERS INC. SILVER SPRING, MD</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE Bethesda</u>		c LENGTH OF STAY IN 1b <u>4 mos 21 DAYS</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BETHESDA SILVER SPRING NURSING HOME</u>		d STREET ADDRESS <u>4601 DRUMMOND AVE.</u>	
3 NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>BAKER</u> Last <u>HIGHSAW</u>		4 DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>19 67</u>	
5 SEX <u>FE</u>	6 COLOR OR RACE <u>C</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-3-85</u>
9a AGE (In years last birthday) <u>82</u> yrs		9b IF UNDER 1 YEAR Months <u>28</u> Days <u>19</u> Hours <u>67</u> Min	
10a USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>KANSAS</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Moses Baker</u>		14 MOTHER'S MAIDEN NAME <u>Sarah Jane Willson</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>---</u>	
17 INFORMANT <u>PATIENT'S CHART -</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>Dec. 28</u> , 19 <u>67</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>Dec. 28</u> , 19 <u>67</u> , and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Thomas L. Hartman</u> M.D.		22b DATE SIGNED <u>Dec. 28, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>THOMAS L. HARTMAN</u>		22d ADDRESS <u>2001 I ST, N.W., WASHINGTON, D.C.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b DATE THEREOF <u>12-29-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Memphis, Tenn.</u>
24 FUNERAL DIRECTOR ADDRESS <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.</u>		25a REC'D BY REGISTRAR <u>JAN 3 1968</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 1-21 Film #396
1-4-C mt
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7255

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17254

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE WASHINGTON b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL		d. STREET ADDRESS 3820 8th Street, N.W.	
3 NAME OF DECEASED (Type or print) ARLANDO HILL		4 DATE OF DEATH Month 12 Day 17 Year 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/6/30
9 AGE (In years last birthday) 17 yrs		10 IF UNDER 1 YEAR Months 17 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen helper		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11 BIRTHPLACE (State or foreign country) Wash. D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Arlando Hill, Sr.		14 MOTHER'S MAIDEN NAME Sallie Brown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT Sallie Brown-3820 8th Street, N. W.		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Exsanguination Hemorrhage due to Gunshot Wound of Left Lung and Heart. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and Heart. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Yellow employee loading revolver and it discharged bullet hitting deceased in chest.	
20c. TIME OF INJURY Month Day Year 1:10 Hour am 12 17 19 67		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or while <input type="checkbox"/> at work Restaurant	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Restaurant		20f. (City or town) (County) (State) Wheaton Mont Md	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Read		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. READ M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED DEC. 17, 1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) 12/22/67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat.		23d. LOCATION (City or Town) (County) (State) Ft. Meyer Va	
24 FUNERAL DIRECTOR Reynolds Funeral Home		ADDRESS 3015-12th St N.E.	
25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

2255

17255

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>37 days</u>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1536 Douglas N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Edmund</u> Middle <u>E</u> Last <u>Hill</u>		4 DATE OF DEATH <u>Dec 7</u> 19 <u>67</u> Month <u>7</u> Day <u>19</u> Year <u>67</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/20/92</u> 75 years (day) yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Spider Co</u>	
11 BIRTHPLACE (City & State, or foreign country) <u>USA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Alex Hill</u>		14. MOTHER'S MAIDEN NAME <u>Rosa?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-03-4499</u>	
17. INFORMANT <u>Hs. Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Failure of the Circulation</u> DUE TO (b) <u>Carcinoma of Prostate with</u> DUE TO (c) <u>metastases to bones of vertebrae + ribs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 20, 1967</u> to <u>Dec 7, 1967</u> that (I) (we) last saw the deceased alive on <u>Dec 7, 1967</u> , and that death occurred at <u>7:50 P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>J. H. Mink</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>12/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Landover</u>
24. FUNERAL DIRECTOR <u>R.N. Horton Co. 1324 4th St. NW</u>		25a. RECEIVED BY REGISTRAR <u>DEC 13 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17251

1. PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c LENGTH OF STAY IN TB 8hrs./55min.	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		d STREET ADDRESS 7311 Baltimore Ave.	
a NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Alexandria Hotchkiss		4. DATE OF DEATH December 6, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-81
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR: Months 6 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Moore		14. MOTHER'S MAIDEN NAME Mary Becker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 290-10-7983	
17. INFORMANT Hospital Records		Address 7600 Carroll Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC ARREST.			
609X DUE TO (b) C-RAM NEG SEPSIS & SHOCK			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) URINARY TRACT INFECTION			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CVA with Indwelling catheter			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-5-67 , to 12-6-67 , that (I) (we) last saw the deceased alive on 12-6-67 , and that death occurred at 2:55 AM , from causes and on the date stated above			
22a. SIGNATURE J. Ford		22b. DATE SIGNED 12/6/67	
22c. PHYSICIAN'S NAME (Type) JOHN L. FORD		22d. ADDRESS 831 UNIVERSITY BLVD E. SILVER SPRING MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 12/7/67	
23c. NAME OF CEMETERY OR CREMATORY FERTILIZER CEM		23d. LOCATION (City or town) (County) (State) COLUMBIA PARK PROBOCA MD	
24. FUNERAL DIRECTOR W. W. Chambers & Burial & Cremation		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE DEC 11 1967			

CERTIFICATE OF DEATH

17257

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>47 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>615 Hollywood Street</u>		d. STREET ADDRESS <u>615 Hollywood Street</u>	
3 NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Houston</u> Last <u>Houston</u>		4 DATE OF DEATH Month <u>December</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 June 1885</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>J.C. Hood Co.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert Houston</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Keating</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>1918-1919</u>	
16. SOCIAL SECURITY NO. <u>213-58-7034</u>		17. INFORMANT <u>Silver Spring, Md.</u> <u>Mrs. Blanche H. King 815 Hollywood Avenue</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>year</u> , 19 <u>67</u> , to <u>11-20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-20</u> , 19 <u>67</u> , and that death occurred at <u>4:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John N. Andrews</u>		22b. DATE SIGNED <u>12-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>		22d. ADDRESS <u>3601 Coleville Rd Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 26, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate Of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>DATE DEC 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John N. Andrews</u>		25c. REGISTRAR'S NAME <u>John N. Andrews</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 11 and 12, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
17259											
17258											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN It Kensington Garden Sanatorium Kensington Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, d. STREET ADDRESS 4898 Chevy Chase Blvd.						
3. NAME OF DECEASED (Type or print) ELLA STEARNS HUMBLE					4. DATE OF DEATH December 27, 1967						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 26, 1879		9. AGE (In years last birthday) 88			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Lawyer					10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Walter H. Stearns, Jr.					14. MOTHER'S MAIDEN NAME Jessie L. Bowker						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO 022-20-4168		17. INFORMANT John S. Humble-Son			Address Hamover, N.J. 5-Colonial Way	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho pneumonia 4 + 00 DUE TO Chronic Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)											
INTERVAL BETWEEN ONSET AND DEATH 6 days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 17 Dec., 1967 to 27 Dec., 1967 , that (I) (we) last saw the deceased alive on 26 Dec., 1967 , and that death occurred at 8:05 M. from causes and on the date stated above.											
22a. SIGNATURE Horace H. Custis, Jr.					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) Horace H. Custis, Jr.			
22d. ADDRESS 1852 Columbia Road, N.W. Wash. D.C.					22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-28-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Md.					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.					25a. JAN BY REGISTRAR 3-1868		25b. REGISTRAR'S SIGNATURE [Signature]				

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

172599

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>20 A.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>	
d. STREET ADDRESS <u>4526 Rosedale Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Addie Hutchinson</u>		4. DATE OF DEATH <u>Dec. 30 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1889</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Holliday</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Marion Greenwood</u>		Address <u>10960 Rockview Drive Reton M.D.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute -</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>last</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF DEATH Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>12/30/67</u>	
EXAMINER'S NAME (Type) <u>John G Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, or other disposition <u>Burial</u>	23b. DATE THEREOF <u>3 Jan 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Mont. Md</u>
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>		7557 Wisconsin Ave Bethesda, Md	
25a. REC'D BY REGISTRAR <u>JAN 5 1968</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATE

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
ELIZABETH (NMN) INCHES						12 Month 24 Day 67 Year			3-40A- M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE	WHITE	SEPT 11, 1886		81 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
CANADA	U.S.			MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
KENSINGTON		GARRALL HALL SAN.			HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Md.			Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Unknown
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Richard T EVANS						Elizabeth McTAVISH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
Yes, No <input checked="" type="checkbox"/> (unknown)			577-244202		Robert Jones				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS								15 MIN	
4201 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE								-	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) GENERALIZED ARTERIOSCLEROSIS								-	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								-	
SEVERITY									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION					
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 26, 1966, to DECEMBER 24, 1967, that (I) (we) lost saw the deceased alive on DECEMBER 24, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
Henry M. Lowden						MD		12-24-67	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Francis H. Barber						5206 National Dr. Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Dec. 28 1967		Laytonsville		Laytonsville Mont. Md			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis H. Barber Laytonsville Md						DATE JAN 2 1968		Francis Judge	

CERTIFICATE OF DEATH

11261

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>17 days</u>		d. STREET ADDRESS <u>3601 - Conn. Ave. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Frederick</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edwin Warley James</u>		4. DATE OF DEATH <u>Dec. 22 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17 1907</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>public roads</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edw. James James</u>		14. MOTHER'S MAIDEN NAME <u>Alice Warley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>879-44-603A</u>	
17. INFORMANT <u>Alice James</u>		Address <u>daughter</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO (b) <u>Int. Obstruction</u> DUE TO (c) <u>Int. Obstruction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>gone for 2 wks due to pay</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>Dec 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 22 1967</u> , and that death occurred at <u>6:50 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stewart Clapp</u>		22b. DATE SIGNED <u>Dec 22 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>		22d. ADDRESS <u>4740 Chevy Chase Drive N.W. Chevy Chase Md 20015</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>CREMATION</u>	<u>Dec 24 1967</u>	<u>Cedar Hill Crematory</u>	<u>SUITLAND, MARYLAND</u>
24. FUNERAL DIRECTOR <u>Joseph Gawlick's Sons Inc. WASH. DC.</u>		25a. REC'D BY REGISTRAR <u>Jan 3 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c LENGTH OF STAY IN 1b <u>67 days</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d STREET ADDRESS <u>7109 Fairfax Road</u> e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Gladys P. Jenkins</u> First Middle Last 4 DATE OF DEATH <u>Dec 7 1967</u> Month Day Year		5 SEX <u>F</u> 6 COLOR OR RACE <u>white</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B DATE OF BIRTH <u>11/16/85</u> 9. AGE (in years last birthday) <u>82</u> yrs 8 UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u> 10b KIND OF BUSINESS OR INDUSTRY <u>no</u> 11 BIRTHPLACE (County & State, or foreign country) <u>New York</u> 12 COUNTRY OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Edison Samuel Palmer</u> 14 MOTHER'S MAIDEN NAME <u>Mary Laura O'Neill</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16 SOCIAL SECURITY NO <u>216-46-7177</u> 17 INFORMANT <u>Susan J. Dale Pittsburgh, Penn.</u> Address <u>39 San Antonio</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Decomp. with edema</u> 4221 DUE TO (b) <u>Uremia, Terminal, severe</u> DUE TO (c) <u>Arteriosclerosis, generalised</u>		INTERVAL BETWEEN ONSET AND DEATH <u>37 days</u> <u>2 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma, metastatic from left breast</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>no</u> 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office building, etc.) <u>no</u> 20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1947</u> to <u>12-7-</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-7-</u> 19 <u>67</u> , and that death occurred at <u>2:30</u> P.M. from causes and on the date stated above.			
22a SIGNATURE <u>Stewart C. Lapp</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b DATE SIGNED <u>12-7-67</u>			
22c PHYSICIAN'S NAME (Type) <u>Stewart C. Lapp M.D.</u> 22d ADDRESS <u>4740 Chevy Chase Dr. N.W. Wash. D.C.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b DATE THEREOF <u>12-11-67</u> 23c NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> 23d LOCATION (City or Town) (County) (State) <u>Bronx, New York</u>			
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> ADDRESS <u>no</u> 25a REC'D BY REGISTRAR <u>DEC 11 1967</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17263

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>23 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Portsmouth</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>			d. STREET ADDRESS <u>801 Potomac Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>Margaret Sarah Jenkins</u>			4 DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>19 67</u>		
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>January 31, 1891</u>	9 AGE (n years last birthday) <u>76</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>John Green</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO <u>Not available</u>		
17. INFORMANT <u>The Medical Records</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic coronary artery disease</u> DUE TO (c) <u> </u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of vulva - bilateral radical groin dissection (11 days)</u>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> pm <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (X) (this hospital) attended the deceased from <u>November 11, 19 67</u> , to <u>December 4, 19 67</u> , that (X) (we) last saw the deceased alive on <u>December 4, 19 67</u> , and that death occurred at <u>6:45</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Dr. Alfred S. Ketcham (Sign. below)</u> M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4 December 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alfred S. Ketcham M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>12/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Snelling Funeral Home</u>		23d. LOCATION (City or Town) (County) (State) <u>Portsmouth, Virginia</u>	
24. FUNERAL DIRECTOR <u>J. Wm Lee & Sons, 300 4th St, Wash, D.C.</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health. If health removal, cremation, or removal and in any event, within 72 hours after death, should be filed with the State Dept. of Health.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHARON Nsg Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minnie Olive Johnson</u>		4. DATE OF DEATH <u>Dec 3 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>100</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Richmond, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Lane Perry</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Bradley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>220-57-12417</u>	
17. INFORMANT <u>Leslie E. Johnson</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke pneumonia</u> DUE TO <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>Yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured Rt hip</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>Nsg Home</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this <u>Physician</u>) attended the deceased from <u>4/22</u> , 19 <u>66</u> to <u>12/3</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12/3/1967</u> , and that death occurred at <u>3:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>C.H. Ligon</u>		22b. DATESIGNED <u>12/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C.H. LIGON MD.</u>		22d. ADDRESS <u>SANDY SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THROF <u>12/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	23d. LOCATION (County, State) <u>Montgomery County, Md.</u>
24. FUNERAL DIRECTOR <u>Robert Pumphrey Funeral Home, Rockville Md</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

17265

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN It 16 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		e. STREET ADDRESS 2015 Park Road N.W.	
3 NAME OF DECEASED (Type or print) Daisy Irene Johnstone		4 DATE OF DEATH Month Dec. Day 20 Year 1967	
5 SEX Fe	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/1880
9 AGE (in years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months 20 Days 9 Hours 67	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Boyer		14. MOTHER'S MAIDEN NAME Sylindia Bright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Nursing Home Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1992 Bronchopneumonia DUE TO (b) Metastatic carcinoma DUE TO (c) lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 19 , 19 67 to Dec. 19 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 20 , 19 67 , and that death occurred at 5:00 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Myron L. Lenkin		22b. DATE SIGNED 12-20-67	
22c. PHYSICIAN'S NAME (Type) MYRON L. LENKIN		22d. ADDRESS 2509 Shorefield Road Wheaton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-22-67	23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REGISTERED BY REGISTRAR DEC 26 1967	

Cleared by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

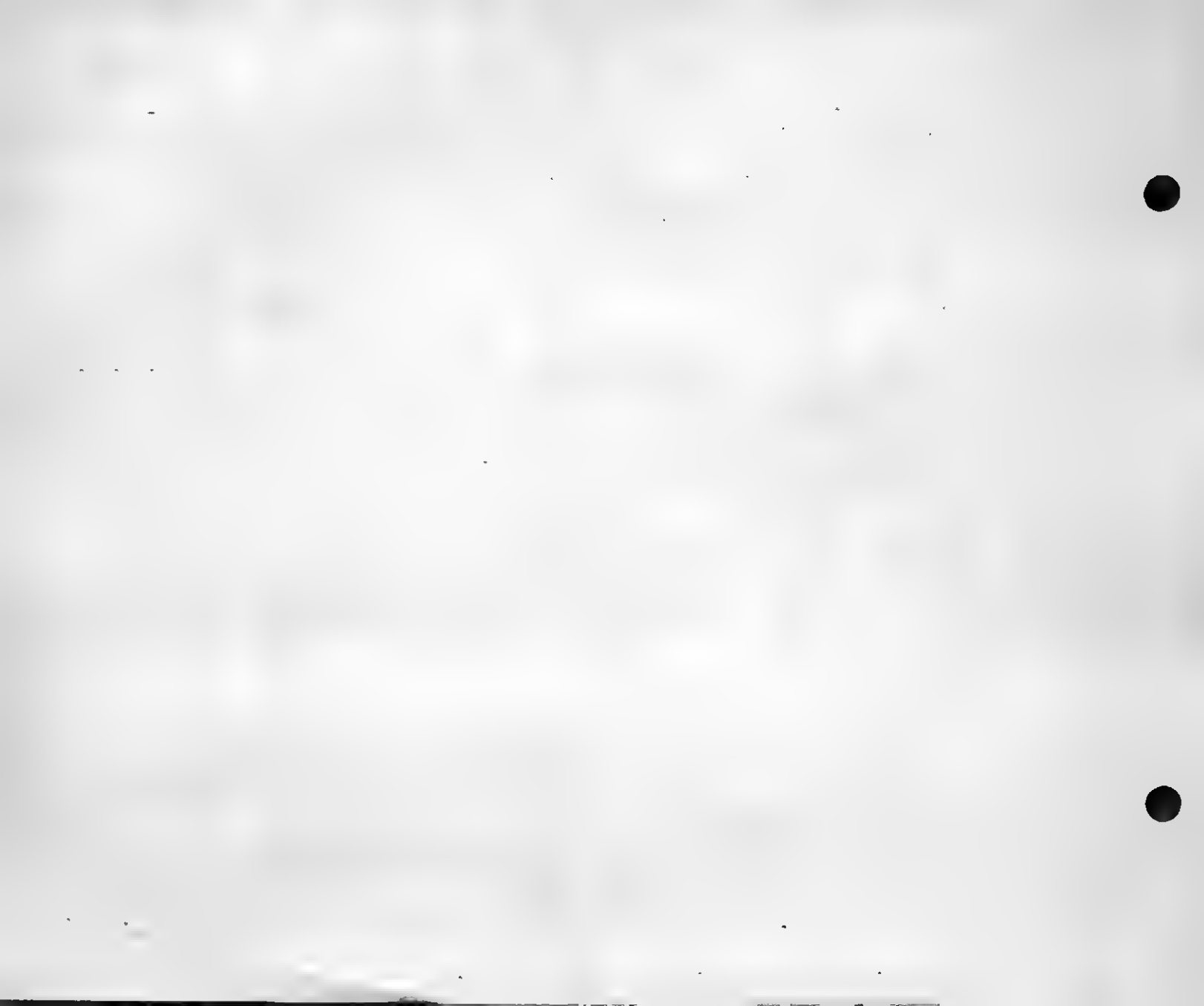
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17266

VR A15ME (S)
6M 1/67



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1266

17267

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>9 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1220 East West Highway</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>1220 East West Hwy</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FAY BRICKMAN KEMELHOR</u> First Middle Last 4. DATE OF DEATH <u>DEC. 4 1967</u> Month Day Year		5. SEX <u>Fe</u> 6. COLOR OR RACE <u>CAUC</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>12-24-1899</u> 8. AGE (In years last birthday) <u>67</u> yrs W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>POLAND</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S. (NAT.)</u>	
13. FATHER'S NAME <u>PAUL BRICKMAN</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ?</u> 16. SOCIAL SECURITY NO <u>095-16-9082</u> 17. INFORMANT <u>2521 AVALON PL., HYATTSVILLE, MRS. ADELE FEINDERSH (DAUGHTER)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>DEC. 4 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-7-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL Cem.</u> 23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON VA.</u>	
24. FUNERAL DIRECTOR <u>GONDBERG FUNERAL HOME</u> ADDRESS <u>4217 9th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17259

1 PLACE OF DEATH a COUNTY <u>Montgomery County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Prince Georges</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>1 day</u>	
d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hosp</u>		e STREET ADDRESS <u>6500/1 Richards Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Kendall, MR. JAMES HENRY</u>		f DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-6-1869</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mercantile business</u>		10b KIND OF BUSINESS OR INDUSTRY <u>mercantile</u>	9 AGE (In years last birthday) <u>98</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>Chicago, Illinois</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>George H. Kendall</u>		14 MOTHER'S MAIDEN NAME <u>Lastley</u> not applicable	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>Md. St. Aid 1604 3379690</u>	
17 INFORMANT <u>Mr. Earnest Kendall</u> Address <u>504 Dennis Ave, S.S.</u>		<u>Mr. James C. Kendall</u> Address <u>11811 Columbia Pike</u>	
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4341</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Congestive heart failure</u> (b) <u>6 hrs.</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> , 19 <u>66</u> , to <u>12/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> , 19 <u>67</u> , and that death occurred at <u>6 P.M.</u> from causes and on the date stated above			
22a SIGNATURE <u>A. J. Thibadeau</u>		22b. DATE SIGNED <u>12/20/67</u>	
22c PHYSICIAN'S NAME (Type) <u>A. J. Thibadeau</u>		22d ADDRESS <u>10111 Colcolville Road, Silver Spring, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Dec. 21, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>John P. Thomas</u> ADDRESS <u>8434 Ponia Avenue, Silver Spring, Md.</u>		25a REC'D BY REGISTRAR <u>DEC 27 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Thomas Judge</u>			

CERTIFICATE OF DEATH

17269

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>xxxxxxx</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN lb <u>4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xxxxxxx</u> D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1429-E. Capitol St.</u> <u>xxxxxxx</u>	
3 NAME OF DECEASED (Type or print) <u>LEE B. KISTLER</u>		4 DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/3/1847</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Plate Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US GOV't (Ret)</u>	9 AGE (In years last birthday) <u>83</u> yrs
11 BIRTHPLACE (County & State or foreign country) <u>Ill.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Lemon Kistler</u>		14 MOTHER'S MAIDEN NAME <u>Orcelia (Last Name Unknown)</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO <u>579-60-2207</u>	
17 INFORMANT Address <u>Mrs. B. K. Lloyd, Potomac, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN TUMOR</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>NW</u> , 19 <u>67</u> to <u>Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-13</u> 19 <u>67</u> , and that death occurred at <u>9:20</u> PM, from causes on and on the date stated above			
22a. SIGNATURE <u>Bernard A Fitzgerald</u> M.D.		22b. DATE SIGNED <u>12-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A FITZGERALD</u>		22d. ADDRESS <u>217 UNIV. BLVD E Silver Sp., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Pr. Geo, Md.</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home, 300 4th, NE, Wash, DC</u>		25a. REC'D BY REGISTRAR <u>DEC 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Johnnie J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



200



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery-</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>Bethesda</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8502 Rayburn Rd.</u>		d STREET ADDRESS <u>8502 Rayburn Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>J Leo Kolb</u>		4 DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 13, 1911</u>
9 AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. MARSHALL</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>	
11 BIRTHPLACE (State or foreign country) <u>D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>JOSEPH LEO KOLB, JR.</u>		14 MOTHER'S MAIDEN NAME <u>LOUISE A. STANTON</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>II</u>		16 SOCIAL SECURITY NO <u>(WIFE) MARY AGNES KOLB - SAME AS # 2</u>	
17 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>976X</u> IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Head -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot self in head with 38 cal. Revolver -</u>	
20c TIME OF INJURY Month Day Year <u>7:00 pm 12/26/1967</u>	20d INJURY OCCURRED While <input type="checkbox"/> not While <input checked="" type="checkbox"/> at work at work	20e PLACE OF INJURY (Home farm factory, street, office, etc.) <u>Home</u>	20f (City or town) (County) (State) <u>Bethesda Montgomery Md</u>
21 I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John B. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>12/26/67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12-30-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Holy Rood Cem.</u>	23d LOCATION (City or town) (County) (State) <u>WASHINGTON, D.C.</u>
24 FUNERAL DIRECTOR <u>James E. D'Sal - D'Sal Funeral Home - Wash D.C.</u>		25a REC'D BY REGISTRAR <u>DATE JAN 2 1968</u>	25b REGISTRAR'S SIGNATURE <u>James E. D'Sal</u>

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17271

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM3. Page 5 may be retained for your files.


TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Michigan</u> b. COUNTY <u>Wayne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY in lb. <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>18029 Schonheer Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Dorothy Lampman</u>		4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1893</u>
9. AGE (In years lost birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wyatt</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Vickery</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>William A. Lampman</u>		Address <u>18029 Schonheer Ave. Detroit, Michigan</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Intermittent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>DEC. 8, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		Address <u>434 Georgia Avenue</u> (City or town) (County) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Windsor Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Ontario, Canada</u>	
24. FUNERAL DIRECTOR <u>G. Glen Carter</u> 434 Georgia Avenue		25a. REC'D BY REG. STRAR <u>Charles J. J...</u>	
Varner E. Pumphrey, Inc. Silver Spring, Md.		DATE <u>DEC 11 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLERKED WITH MEDICAL EXAMINER - JFL

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17272											
CERTIFICATE OF DEATH											
17272											
1. PLACE OF DEATH a COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a STATE Maryland b COUNTY Montgomery					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c LENGTH OF STAY IN 1b D.O.G.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital of Silver Spring						d STREET ADDRESS 500 Highgate Terrace 1500 Forest Glen Rd., S.S. Md.				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Mark First Everett Middle Lavery Last			4. DATE OF DEATH Month December Day 6 Year 67								
5 SEX male		6 COLOR OR RACE cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-28-66		9. AGE (In years lost birthday) 16 months		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) minor				10b. KIND OF BUSINESS OR INDUSTRY not employed		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John M. Lavery						14. MOTHER'S MAIDEN NAME Iris Mayberry					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO none		17. INFORMANT Mother - 500 Highgate Ter. Silver Spring, Md. IRIS LAVERY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PNEUMONIA 745X DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) SCOLIOSIS + KYPHOSIS + DEFORMITY OF THORAX DUE TO (c) BIRTH DEFECTS OF SPINE + RIBS										INTERVAL BETWEEN ONSET AND DEATH 16 mos 16 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC URINARY TRACT INFECTION DUE TO CONGENITAL G-U DEFECTS POSTOPERATIVE HYDROCEPHALUS + MYELOMENINGOCELE											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/31 , 19 66 , to 12/6 , 19 67 , that (I) (we) last saw the deceased alive on October 8 , 19 67 , and that death occurred at 12:51 A.M. from causes and on the date stated above.											
22a. SIGNATURE 						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/6/67			
22c. PHYSICIAN'S NAME (Type) George Cohen						22d. ADDRESS 9919 Georgia Ave., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec. 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory				23d. LOCATION (City or town) (County) (State) Prince Georges Co. Md.			
24. FUNERAL DIRECTOR Thomas E. Purphey, Inc.				25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE Charles Judge			
25c. ADDRESS 8434 Georgia Avenue Silver Spring, Md.				DATE DEC 11 1967							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

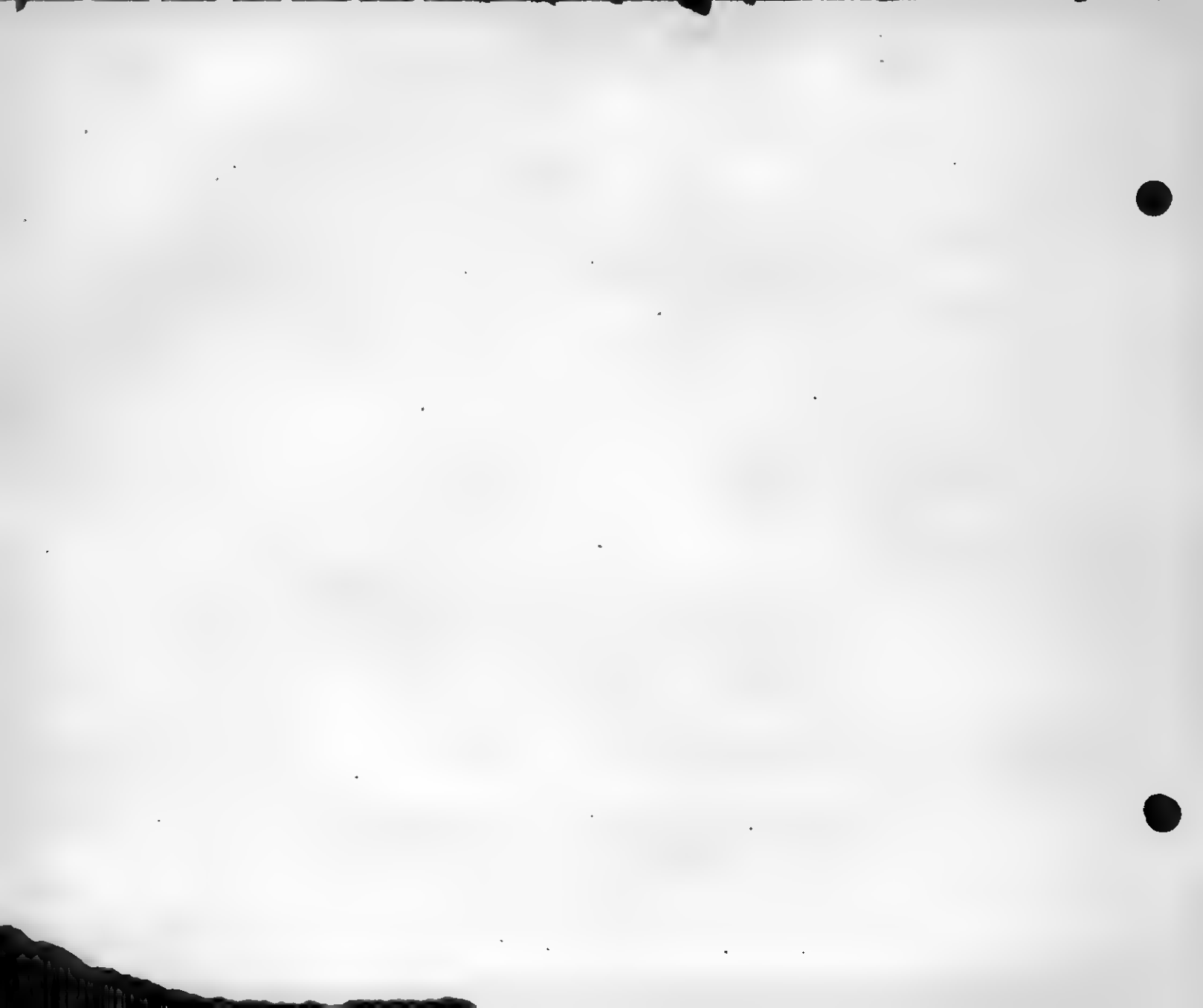
1. PLACE OF DEATH a. COUNTY <u>in. 100000</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Kearney</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Hill Sanatorium</u>		2. USUAL RESIDENCE (Where deceased lived; If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>417 Van Meter Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HATTIE M. LAYTON</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 7, 1876</u>	
9. AGE (in years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months <u>01</u> Days <u>01</u> Hours <u>01</u> Min. <u>01</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. BIRTHPLACE (County & State, or foreign country) <u>Leesburg, Virginia</u>	
13. FATHER'S NAME <u>Clarence Gram Head</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Rollins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>570-62-0516-5</u>	
17. INFORMANT <u>417 Van Meter Street, N.W.</u>		18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> DUE TO (b) <u>Cardiovascular Renal Disease</u> DUE TO (c) <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1967</u> to <u>Dec 22, 1967</u> that (I) <u>last</u> saw the deceased alive on <u>Dec 18, 1967</u> and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. W. Hedges, M.D.</u>		22b. DATE SIGNED <u>Dec 22, 1967</u>	
22c. PHYSICIAN'S ADDRESS (Type or print) <u>Union Cemetery, Md.</u>		22d. ADDRESS <u>6940 Piney Branch Rd, NW, Wash. DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 27, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Leesburg, Va. Wash. DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Hedges</u>		25a. REC'D BY REGISTRAR <u>John C. Hedges</u>	
25b. REGISTRAR'S SIGNATURE <u>John C. Hedges</u>		DATE <u>DEC 28 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cedar Haven Rest Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> d. STREET ADDRESS <u>1660 Lainer Pl., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Florence</u> First <u>Martin</u> Middle <u>Leary</u> Last 4. DATE OF DEATH <u>December 7</u> Month <u>1967</u> Day <u>Year</u>						5. SEX <u>Female</u> 6. COLOR OR RACE <u>Cauc</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Mar 31, 1894</u> 9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR <u>73</u> IF UNDER 24 HRS. Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>John H. Martin</u> 14. MOTHER'S MAIDEN NAME <u>Effie Burritt</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No*</u> (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>---</u> 17. INFORMANT <u>John H. Martin,</u> Address <u>1660 Lainer Pl., Wash.</u>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA - Rt lower lobe</u> DUE TO <u>PARKINSON'S DISEASE - Advanced</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>CHRONIC ARTERIO SCLEROSIS</u> DUE TO <u>10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>a.m.</u> p.m. 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Asheville</u> (County) <u>North Carolina</u> (State) 						21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 <u>62</u> , to <u>12-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 6th</u> , 19 <u>67</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Richard B. Perry MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Richard B. Perry</u> 22d. ADDRESS <u>12-7-67</u> 22b. DATE SIGNED <u>12-7-67</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12/9/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u> 23d. LOCATION (City, town or county) <u>Asheville</u> (State) <u>North Carolina</u>						24. FUNERAL DIRECTOR <u>L & R FUNERAL HOME</u> ADDRESS <u>300 4th St NE</u> 25a. REC'D BY REGISTRAR <u>11 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

2275

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1204 Oakview Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Charles Leary</u>		4. DATE OF DEATH <u>Dec 7 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/04</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Administrator U. S. Gov't.</u>		11. BIRTHPLACE (County & State or foreign country) <u>Montana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John C. Leary</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Kelly</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WWII</u>	
16. SOCIAL SECURITY NO <u>577-60-0117</u>		17. INFORMANT <u>Mrs. Margaret Leary</u> Address <u>1204 Oakview Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443x</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO <u>10 years</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1963</u> to <u>Dec 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 7 1967</u> , and that death occurred at <u>2:40 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Blaine H. Elg</u>		22b. DATE SIGNED <u>12/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. ELG</u>		22d. ADDRESS <u>1641 Colander Rd Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Dec. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>W B Thomas 8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>DEC 13 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

11276

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 16 DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle Bonifant Last LEIBIG		4. DATE OF DEATH Month DECEMBER Day 28 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/14/85
9. AGE (In years last birthday) 82		10. UNDER 1 YEAR Months 1 Days 16	11. UNDER 24 HRS Hours 48 Min 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Chc Home	
11. BIRTHPLACE (County & State or foreign country) Columbia, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Bonifant		14. MOTHER'S MAIDEN NAME Helen Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 122	
17. INFORMANT Thomas L. Leibig		18. ADDRESS 1100 Silver Spring, Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Acute pulmonary embolism DUE TO (b) Congestive heart failure DUE TO (c) Left ventricular cardiac arrest, disease		INTERVA. BETWEEN ONSET AND DEATH 1 hr 48 hrs 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 1955, to Dec , 1967, that (I) (we) last saw the deceased alive on Dec 27 1967 , and that death occurred at 9:10 AM , from causes and on the date stated above			
22a. SIGNATURE A. Dement Bonifant M.D.		22b. DATE SIGNED 12-29-67	
22c. PHYSICIAN'S NAME (Type) A. DEMENT BONIFANT M.D.		22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.	
23a. BURIAL, CREMATON, REMOVAL (Specify) Reburied	23b. DATE THEREOF Dec. 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Parlanna Cemetery	23d. LOCATION (City or Town) (County) (State) ockville, Maryland
24. FUNERAL DIRECTOR James H. Bonifant		25. REG'D BY REGISTRAR JAN 8 1968	
26. ADDRESS 1100 Silver Spring, Md.		27. REGISTRAR'S SIGNATURE John J. Judge	

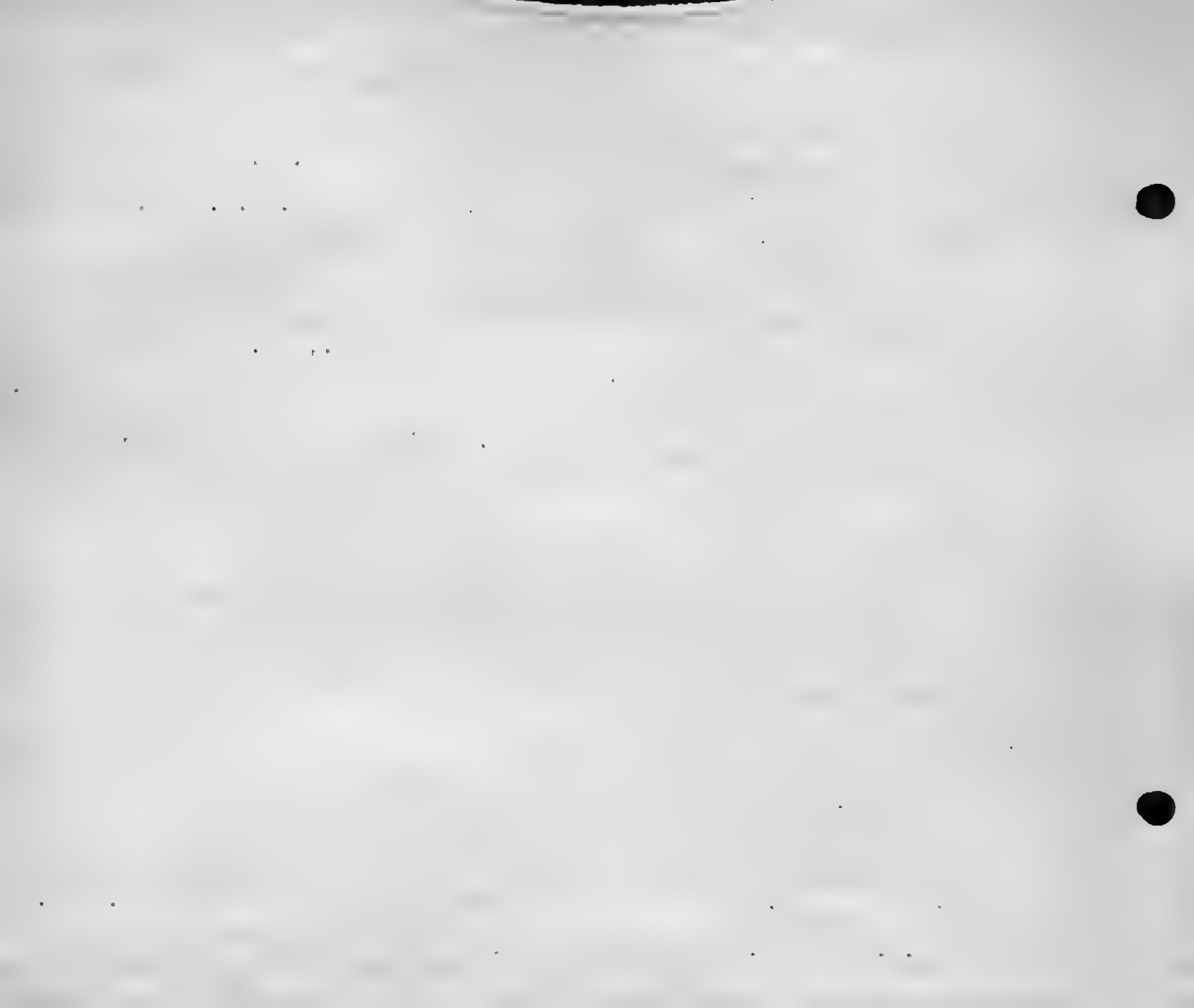


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11277

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 2911 Newark St. N.W. Apt. 35 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Susie Middle Mary Last Leigh		4. DATE OF DEATH Month Dec Day 6 Year 1967									
5. SEX female		6. COLOR OR RACE white									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/1881									
9. AGE (In years last birthday) 86 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Charlotte Co., Va.									
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Jamerson Fulton Mercer White									
14. MOTHER'S MAIDEN NAME Mary Frances Henderson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)									
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Irving Abramson									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4500 DUE TO Conditions, if any, which gave rise to immediate cause } (b) Generalized infected decubiti DUE TO (c) Generalized arteriosclerosis cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 3 yrs 4 yrs									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)		(County)									
(State)		21. I certify that (I) (this hospital) attended the deceased from 6-20, 1967 to 12-6, 1967 , that (I) (we) last saw the deceased alive on 11-7, 1967 , and that death occurred at 1:20 PM , from the causes and on the date stated above.									
22a. SIGNATURE Herbert L. Tanenbaum M.D.		22b. DATE SIGNED 12-6-67									
22c. PHYSICIAN'S NAME (Type) HERBERT L. TANENBAUM		22d. ADDRESS 4400 Conn. Ave. N.W. Wash DC									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/8/67									
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges Co. Md.									
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D. C.		25a. REC'D BY REGISTRAR DEC 7 1967									
25b. REGISTRAR'S SIGNATURE J. Charles Judge											



17278

23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12/4/67	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d LOCATION (City or Town) (County) (State) Silver Spring, Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike	ADDRESS Rockville, Md.	25a REC'D BY REGISTRAR DATE DEC 6 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON c. LENGTH OF STAY IN (b) 6 days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 6445 LUZON AVE. N.W.	
3. NAME OF DECEASED (Type or print) EVA AURELIA LESTER First Middle Last 4. DATE OF DEATH Dec. 4, 1967 Month Day Year		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F	6. COLOR OR RACE CAUS	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-1887 9. AGE (In years lost birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOV'T CLERK		10b. KIND OF BUSINESS OR INDUSTRY GOV'T	
11. BIRTHPLACE (Country & State, or foreign country) COLUMBIA S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William F. Lester		14. MOTHER'S MAIDEN NAME Minnie, A. North	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 215-44-5379	17. INFORMANT self
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cerebrovascular insufficiency DUE TO (c) Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 1 hour 18 mos years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (th's hospital) attended the deceased from July 12/2 1969 , to Dec. 4, 1967 , that (we) last saw the deceased alive on 12/2 1969 , and the death occurred at 8:15 PM , from causes and on the date stated above.			
22a. SIGNATURE James R. Coleman MD		22b. DATE SIGNED 12/4/67	
22c. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN		22d. ADDRESS 9741 COLUMBIA BLVD SILVER SPRING, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 12/7/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR St. Anne's Co. 2901 14th NW DC		25a. REC'D BY REGISTRAR DEC 7 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17280

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>15+ years</u>		d. STREET ADDRESS <u>13130 Holbridge Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RUTH LEVENSON</u>		4. DATE OF DEATH <u>DEC. 10 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 27, 1922</u>
9. AGE (in years last birthday) <u>44 yrs</u>		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MAX CULICOVER</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>HUSBAND</u> Address <u>SAME</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Pulmonary insufficiency</u> DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Infiltrating Duct Cell Carcinoma of Breast</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>24 Hours</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour: <u>—</u> m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1963</u> to <u>Dec. 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec. 10, 1967</u> , and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen, M.D.</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Dec. 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>B'nai Israel Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Oxon Hill, Maryland.</u>
24. FUNERAL DIRECTOR <u>Donald M. Stein</u>		25a. REC'D BY REGISTRAR <u>DEC 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>new Memorial Funeral Home St., N.W. - Wash., D.C.</u>	

CERTIFICATE OF DEATH

17281

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN lb <u>14 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS SANITORIUM</u>		d. STREET ADDRESS <u>8606 Garland Ave</u>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE C. Lewis</u>		4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>	
13. FATHER'S NAME <u>HENRY BOWMAN</u>		14. MOTHER'S MAIDEN NAME <u>IDA MORGAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>172-01-033-88</u>	
17. INFORMANT <u>Mr. David P. Reigel</u>		Address <u>8606 Garland Ave. T. P. Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Vascular Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 1</u> , 19 <u>67</u> , and that death occurred at <u>3:30 P.</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u> M.D.		22b. DATE SIGNED <u>12-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>217 UNIV. BLVD. E., SILVER SPRING, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Not Darby Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>New York</u>
24. FUNERAL DIRECTOR <u>William Nelson</u>		25a. REC'D BY REGISTRAR <u>DEC 5 1967</u>	
ADDRESS <u>2524 Carroll St NW 10</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and file with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17282

17282

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if in hospital on Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>30 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>7709 Royston Street</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Leland Price Lewis</u>		4 DATE OF DEATH Month Day Year <u>December 28 19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>25 March 1924</u>
9 AGE (In years lost birthday) <u>43</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edgar H. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Deer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes 1941-45</u>		16. SOCIAL SECURITY NO <u>Not Available</u>	
17. INFORMANT <u>The Medical Records</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hepatorenal Failure</u> DUE TO (c) <u>Metastatic Teratocarcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> <u>24 hours</u> <u>3 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>28 November, 19 67</u> , to <u>28 Dec.</u> , 19 <u>67</u> , that <u>XX</u> (we) last saw the deceased alive on <u>28 December 19 67</u> , and that death occurred at <u>4:58 M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Charles M. Haskell</u>		22b. DATE SIGNED <u>1967</u> <u>29 December</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles M. Haskell, M. D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Culpepper National</u>	23d. LOCATION (City or Town) (County) (State) <u>Culpepper, Virginia</u>
24. FUNERAL DIRECTOR <u>Covington-Martin</u>		25a. RECD BY REGISTRAR <u>3 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17283

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>		c. LENGTH OF STAY IN 1b <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to, give street address) <u>Washington Sanitarium + Hospital</u>		d. STREET ADDRESS <u>1707 Priscilla dr.</u>	
3. NAME OF DECEASED (Type or print) <u>JESSE</u> First <u>EDGAR</u> Middle <u>LITTLE</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-88</u> 9. AGE (In years last birthday) <u>79</u> YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cash Adjuster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ILL.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Little</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>Pt. Chart.</u>	
17. INTERMENT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage L. hemisphere</u> DUE TO (b) <u>(Intercerebral & probably from</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>by fracture)</u> DUE TO (c)			INTERVA. BETWEEN ONSET AND DEATH <u>12/17/67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-4</u> , 19 <u>67</u> , to <u>12-16</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>8:00 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>C. H. Volck</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Volck</u>		22d. ADDRESS <u>831 Union Blvd E S S</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Dec. 19-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Burtonsville Montg. Md.</u>
24. FUNERAL DIRECTOR <u>De Witt Donaldson</u> ADDRESS <u>Laurel, Md</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17284

FOR STATE
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 4 YEARS		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOM. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2122 ARCOLA AVENUE		d. STREET ADDRESS 2122 ARCOLA AVE. • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JOHN F. LONG		4 DATE OF DEATH Month DEC. Day 5 Year 1967	
5 SEX M	6 COLOR OR RACE CAUC	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-17-1949
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs 18 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 IF UNDER 24 HRS
11 BIRTHPLACE (State or foreign country) WASH., D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JOHN B. LONG		14 MOTHER'S MAIDEN NAME EVELYN L. RIGGS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 212-54-2107	
17 INFORMANT FATHER		Address 2122 Arcola Avenue Silver Spring, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO SUFFOCATION, ACCIDENTAL. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Deceased used plastic bag about head while inhaling medicine served in judgment.	
20c TIME OF INJURY Month, Day, Year 12-5-67	20d INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	20f (City or town) (County) (State) Silver Spring Montgom. Md.
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Not-natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED DEC. 6, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		Address (City or town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Dec. 8, 1967	23c NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d LOCATION (City or Town) (County) (State) Washington, D.C.
24 FUNERAL DIRECTOR C. Glen Carter 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.		25a REC'D BY REGISTRAR DEC 11 1967	25b REGISTRAR'S SIGNATURE Charles Judge

CERTIFICATE OF DEATH

17285

17285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner Dr. Carlton

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY in 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>C.</u> Last <u>Louthan</u>		4. DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/92</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk&typist U.S. News & World Report</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Baxter Clegg</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Atwater</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>579-28-6532</u>	
17. INFORMANT <u>Robert B. Louthan</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic breast carcinoma</u> DUE TO <u>in multiple viscera</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>Sept 17</u> , 1958, to <u>Dec 31</u> , 1967, that <u>(1)</u> (we) last saw the deceased alive on <u>Dec 31</u> , 1967, and that death occurred at <u>8:45pm</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Harry N. Carlton, MD</u>		22b. DATE SIGNED <u>Jan 1, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON, MD</u>		22d. ADDRESS <u>8811 Columbia Rd. S.S. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>1/3/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md.</u>
24. FUNERAL DIRECTOR <u>S.H. Hines Co. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>DATE 3 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (11)
6M 1/67

<div>7286</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>17286</div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if inst. tut on Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Germantown</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Germantown</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt #1 King Valley Rd.</u>						d. STREET ADDRESS <u>Rt #1 King Valley Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert</u> First <u>Julian</u> Middle <u>Lowe</u> Last <u>Jr.</u>						4. DATE OF DEATH Month <u>Dec</u> Day <u>12</u> Year <u>1967</u>					
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 31 1967</u>		9. AGE (In years past birthday) yrs <u>3</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min <u>13</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herbert Julian Lowe</u>						14. MOTHER'S MAIDEN NAME <u>Martha Branhower</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronch. Pneumonia</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)							
20c. TIME OF DEATH Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John G. Ball</u>				EXAMINER'S NAME (Type) <u>John G. Ball</u>				22. DATE SIGNED <u>12/12/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>				23d. LOCATION (City or Town) (County) (State) <u>Laytonsville, Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber</u> Address <u>Laytonsville, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>DEC 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1287

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>36 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6013 Wilmet Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>F</u> Last <u>LUNCH</u>		4 DATE OF DEATH Month <u>DEC</u> Day <u>31</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6/21/00</u>
9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Ross Watts</u>		14 MOTHER'S MAIDEN NAME <u>Mildred Sobel</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17 INFORMANT <u>Margaret Gray</u> Address <u>1300 So 20th St Birmingham Ala</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>5810</u> <u>Carcinoma of Liver</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO (c) DUE TO (c) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. pm <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 29</u> , 19 <u>67</u> , to <u>date</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Dec 30</u> , 19 <u>67</u> , and that death occurred at <u>6:50</u> M, from causes and on the date stated above			
22a SIGNATURE <u>John G Ball</u>		22b. DATE SIGNED <u>31 Dec 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN G BALL</u>		22d ADDRESS <u>MONTGOMERY COUNTY MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>1-6-1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Crematory</u>	23d. LOCATION (City or town) (County) (State) <u>Bladensburg Dist</u>
24 FUNERAL DIRECTOR <u>Wm. Hamilton & Co. 517-11-1150 SE DC</u>		25a. REGISTRY REGISTRAR <u>JAN 9 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11288

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA-Montgomery General Hospital		d. STREET ADDRESS 905 Woodington Road	
3. NAME OF DECEASED (Type or print) (Alfonso) Alphonse		4. DATE OF DEATH Month 12- Day 19- Year 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-1913
9. AGE (in years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min	
11a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Cement layer		11b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH MACK		14. MOTHER'S MAIDEN NAME VERA JOHNSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 223-07-6620	
17. INFORMANT Medical Records		Address HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per part) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO (b) infarction; DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) NO INJURY	
20c. TIME OF INJURY Month, Day Year 12-19-67	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, b.d.g., etc.) Columbia Road	20f. (City or town) Baltimore (County) MD (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-23-67	
23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk		23d. LOCATION (City or Town) (County) (State) BALTO. Md.	
24. FUNERAL DIRECTOR MORTON + DYETT F.H. 1701 LAURENS		25a. REC'D BY REGISTRAR DEC 21 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		22. DATE SIGNED DEC. 19, 1967	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

17289

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>5634-Kansas Ave N.W.</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		d. STREET ADDRESS <u>901 ARCOLA Ave. - Wheaton</u>	
3 NAME OF DECEASED (Type or print) <u>ESSIE</u> First <u>HOPE</u> Middle <u>MAKSON</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-6-1882</u>
9 AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>GASTONIA, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Robert Gullick</u>		14 MOTHER'S MAIDEN NAME <u>Mary Linberger</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u> <u>NO</u>		16 SOCIAL SECURITY NO <u>NO</u>	
17 INFORMANT <u>MARY I. Byrd - 5634 Kansas Ave</u>		Address <u>N.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) <u>Cerebral Arteriosclerosis</u>			
DUE TO			
(c) <u> </u>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, all else bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-10, 1967</u> , to <u>12-9, 1967</u> that (I) (we) last saw the deceased alive on <u>12-8-67</u> and that death occurred at <u>6 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Myron L. Leake</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>BURIAL</u>		<u>12-16-67</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
<u>LINCOLN MEMORIAL CEMETERY</u>		<u>SUITLAND, MARYLAND</u>	
24 FUNERAL DIRECTOR <u>JOHN T. RHINES CO.</u> ADDRESS <u>215 12TH STREET, N. E. WASH. D. C.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17290

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring (Takoma Park)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>7713 Carroll Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>"Baby"</u> Middle		4. DATE OF DEATH <u>Magas(m)</u> Month <u>12</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>12-27-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) yrs <u>12</u> IF UNDER 1 YEAR Months <u>9</u> Days <u>12</u> IF UNDER 24 HRS Hours <u>12</u> Min <u>12</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>-</u>	
13. FATHER'S NAME <u>Kenneth A. Magas</u>		14. MOTHER'S MAIDEN NAME <u>Rita L. Goyon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Father (chart) - same as above</u>		Address <u>-</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity - Neonatal Death</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Am 12/27</u> , 19 <u>67</u> , to <u>Pm 12/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/27/67-1m</u> , and that death occurred at <u>6:35PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Frank W. Newberger</u> M.D.		22b. DATE SIGNED <u>12/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK W. Newberger</u>		22d. ADDRESS <u>1110 Spring St. S.I. Sprg, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 2, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>	23d. LOCATION (City or Town) (County) (State) <u>Naugatuck Conn.</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Inc</u>		25a. REC'D BY REGISTRAR <u>8655 G. Ave S.I. Sprg Md.</u>	25b. REGISTRAR'S SIGNATURE <u>JAN 2 1968</u>

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17291

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		e. STREET ADDRESS 24901 Ridge Rd.	
3 NAME OF DECEASED (Type or print) Arthur J. Martineau		4 DATE OF DEATH Month Dec. Day 21 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 16, 1895
9 AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11 BIRTHPLACE (County & State, or foreign country) Montagua, Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Honorio Martineau		14. MOTHER'S MAIDEN NAME Georgianna Garbo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. # 1		16. SOCIAL SECURITY NO. 578-01-6548	
17. INFORMANT Mrs Mary Louise Martineau, Item 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Advanced Arteriosclerotic Cardio-Vascular Disease with Multiple Cerebral Thrombi DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
INTERVAL BETWEEN ONSET AND DEATH 1 month			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) No injury	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. 0 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from November , 19 66 , to December 21, 66 , that (I) (we) lost saw the deceased alive on December 21, 1966 , and that death occurred at 8:05 AM from causes and on the date stated above.			
22a. SIGNATURE <i>M. McKendree Boyer</i>		22b. DATE SIGNED December 22, 1966	
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.		22d. ADDRESS 9701 Church Street Damascus, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DEC 27 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17297

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>District of Columbia</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c LENGTH OF STAY IN TB <u>47.2</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u> <u>901 Arcola Ave.</u>		d STREET ADDRESS <u>111 Seaton Pl. N.W.</u>	
3 NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Mary</u> Last <u>Mason</u>		4 DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/17/1889</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry Catcher & Feeder</u>		9 AGE (In years last birthday) <u>78 yrs</u>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Williamston, No. Carolina</u>	
13. FATHER'S NAME <u>James Rogers</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>578-03-0668</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY <u>42.21</u> IMMEDIATE CAUSE (a) <u>Accred. CVA & Dehydration</u> DUE TO (b) <u>General Aging Process & Debility</u> DUE TO (c) <u></u>		19 INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/21, 1967</u> to <u>12/31, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec. 29, 1967</u> , and that death occurred at <u></u> M, from causes and on the date stated above			
22a SIGNATURE <u>Russell C Bufalino</u>		22b DATE SIGNED <u>Dec 31, 67</u>	
22c PHYSICIAN'S NAME (Type) <u>Russell C Bufalino M.D.</u>		22d ADDRESS <u>1429 University Blvd. W.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>1.5.68</u>	23c NAME OF CEMETERY OR CREMATORY <u>LINCOLN MEM. CEM.</u>	23d LOCATION (City or Town) (County) (State) <u>SUITLAND, MARYLAND</u>
24 FUNERAL DIRECTOR <u>Robt. G. McQuire</u>		25a REC'D BY REGISTRAR <u>1820-9th St. N.W. WASH. D.C.</u>	
25b REGISTRAR'S SIGNATURE <u>James Judge</u>		DATE <u>JAN 9 1968</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

17293

17293

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED WITH MEDICAL EXAMINER

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Silver Spring		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 1207 Barton St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Earl		First		Middle		Last May		4. DATE OF DEATH Month December Day 31 Year 1967	
5 SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 3, 1908		9. AGE (In years last birthday) 59 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Keatill Store Owner		10b. KIND OF BUSINESS OR INDUSTRY Notions		11 BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Isador May				14. MOTHER'S MAIDEN NAME Minnie David					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-24-0866		17. INFORMANT Address Leah May, same as 2 above					
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO 4301 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASHD = CI DUE TO (c) Hypnoleptololamine								INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 1/5/67 to 12/28 , 1967, that (I) (we) lost saw the deceased alive on 12/25 , 1967, and that death occurred at 3:40 AM , from causes on the date stated above									
22a. SIGNATURE Cyril A. Schulman				22b. DATE SIGNED 12/31/67		22c. PHYSICIAN'S NAME (Type) Cyril A. Schulman		22d. ADDRESS 916-19th St N.W. Wash. DC	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1-2-1968		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.			
24. FUNERAL DIRECTOR Goldberg Funeral Home				25a. REC'D BY REGISTRAR DATE 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

1911

1912

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1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 3200 16th STREET N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) DAISY S. MAYFIELD First Middle Last		4 DATE OF DEATH DECEMBER 30 1967 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 15, 1881
9. AGE (In years last birthday) 86 yrs.		if UNDER 1 YEAR Months Days Hours Min if UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME D.D. STEPHENSON		14. MOTHER'S MAIDEN NAME ANNIE SHINN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-07-2066	
17. INFORMANT D NURSINGHOME RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 586x IMMEDIATE CAUSE (a) acute myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cholecystectomy DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 WKS 2 MO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arterio sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 62 to Dec 30 , 19 67 , that (I) (we) last saw the deceased alive on Dec 29, 1967 , and that death occurred at 7:25 AM , from causes and on the date stated above.			
22a. SIGNATURE E. H. Quayle		22b. DATE SIGNED 12-30-67	
22c. PHYSICIAN'S NAME (Type) E. H. Quayle		22d. ADDRESS 1822 Baltimore St. N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 12/30/67	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	23d. LOCATION (City or Town) (County) (State) BLADENSBURG (P.G. Co.) MD.
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS INC. 5130 WISC. AVE N.W.		25a. REC'D BY REGISTRAR WASHINGTON, DC 25b. REGISTRAR'S SIGNATURE JAN 5 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b 5 YRS 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens SANITARIUM		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY All States Hotel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS Washington, D.C. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MAX C. McCaffrey First Middle Last		4. DATE OF DEATH 12-25-1967 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 26 1870 9. AGE (In years last birthday) 97 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. employee		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) VIRGINIA
13. FATHER'S NAME Joseph Hugh McCaffrey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 579-60-2228	
17. INFORMANT E. Murray Norman-17th. & H. St. N.W.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Influenza DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Amplified arteriosclerosis	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan 25, 1968 , to Dec 25, 1967 , that (I) saw the deceased alive on Dec 24, 1967 , and that death occurred at 7:00 AM , from causes and on the date stated above	
22a. SIGNATURE Michael R. Dobridge M.D.		22b. DATE SIGNED Dec 25, 1967	
22c. PHYSICIAN'S NAME (Type) Michael R. Dobridge		22d. ADDRESS 12600 Parkland Drive, Rockville, Md.	
23a. BURIAL CREMATION (Specify) Burial	23b. DATE THEREOF 12/29/67	23c. NAME OF CEMETERY OR CREMATORY Congressional Cem.	23d. LOCATION (City or town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR 1331 Rock. Pike Rockville, Md. DATE JAN 2 1968	
25b. REGISTRAR'S SIGNATURE James Judge			

172295

172295



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
Donald			H. McCallum			Month Day Year		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD	
Male	Cauc	11 May 1888	79 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	2d HOUR
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH	
11201		U.S.A.		WIDOWED		DIVORCED		Md.	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY
Silver Spring			15 Hamilton Street			Salesman			Paint
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY - WTS?	
Md.			Montgomery			Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			
First Middle Last			First Middle Last			15 Hamilton St.			
William			McCallum			Alice Bishop			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or UNKNOWN)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT ADDRESS			
no			487-03-2047			Alvin McCallum 15 Hamilton St.			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROX MATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>									
7.000 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		Hour A.M. P.M.		19					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASS STANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED	
Belden R. Reap		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		12-31-1967	
EXAMINER'S NAME (Type)		ADDRESS		CITY OR TOWN		COUNTY			
BELDEN R. REAP, M.D.		4000 Rockville Rd.		Rockville		Montg.		Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Jan. 3, 1968		Parklawn Cemetery		Rockville, Montg. Md.			
24 FUNERAL DIRECTOR		C. Glen Carter		ADDRESS		8434 Ga. Ave.		REC'D BY REGISTRAR	
Warner E. Pumphrey, Inc.		Silver Spring, Maryland		JAN 8 1968		25b REGISTRAR'S SIGNATURE		James J. Jones	



CERTIFICATE OF DEATH

17297

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN IB <u>20 A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>205 Oxford Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>S JAY</u> First Middle Last <u>McCATHRAN</u>		4 DATE OF DEATH <u>Dec. 10 1967</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 15-1894</u> 9. AGE (in years last birthday) <u>73</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Lawyer</u>		11 BIRTH PLACE (County & State, or foreign country) <u>Washington - DC</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Jay McCathran Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Eaton - Frances Jayphine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>577-54-1410</u>	
17 INFORMANT <u>Mr. R. McCathran Jr.</u> Address <u>Cherry Chase - Md.</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO (b) <u>Coronary arterio-sclerosis</u> DUE TO (c) <u>Emphysema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May, 1967</u> , to <u>2-10, 1967</u> , that (I) (we) lost the deceased alive on <u>12-5 1967</u> , and that death occurred at <u>9:05 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Russell M. Tilley, Jr.</u> M.D.		22b. DATE SIGNED <u>12-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RUSSELL M. TILLEY</u>		22d. ADDRESS <u>4701 MASS. AVENUE N. W., WASHINGTON DC</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>12/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD.</u>
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SONS, 5130 WIS. AVE. N.W. WASH.</u>		25a. REC'D BY REGISTRAR <u>DEC 15 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

17298

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> (Rural)		c. LENGTH OF STAY IN 1b <u>13 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>		e. STREET ADDRESS <u>8610 Manchester Road</u>	
3. NAME OF DECEASED (Type or print) <u>Tracy L. Mc Cauley</u>		4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4 Jan 1887</u>
9. AGE (in years last birthday) yrs. <u>80</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles A.H. Mc Cauley</u>		14. MOTHER'S MAIDEN NAME <u>Ida Lay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>YES</u> <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>565 16 8062A</u>	
17. INFORMANT <u>Helen Baird apt 1208, Silver Springs, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Pulmonary Edema</u> DUE TO (c) <u> </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospita) attended the deceased from <u>21 November, 19 67</u> , to <u>4 December 19 67</u> , that (I) (we) last saw the deceased alive on <u>4 December 19 67</u> , and that death occurred at <u>0630 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Eugene A. Kaplan</u> M.D.		22b. DATE SIGNED <u>4 January 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. Kaplan, Lcdr MC USN</u>		22d. ADDRESS <u>Naval Hospital Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7 DEC 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Fowler & Sons</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO H
ME (5)
/67

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Res before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN Tb <u>3 hr 30 min</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e STREET ADDRESS <u>2040 Livingston Place</u>	
f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>M. Alfred</u> First <u>Nice F.</u> Middle <u>Alley</u> Last		4 DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 4, 1895</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J Edward Fowler</u>		14. MOTHER'S MA DEN NAME <u>Mae AARON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>215-46-2533</u>	
17. INFORMANT <u>Dorothy E. Small (sister)</u>		Address <u>Wash DC</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - Arteriosclerosis</u> DUE TO 4221 (b) <u>Cardio Vascular Disease</u> DUE TO 4025 (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <u>12/3/67</u>		23. ADDRESS (Street, city, town or county) <u>Bethesda, Md.</u>	
24. ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		25. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
26. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		27. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
28. ADDRESS (Street, city, town or county) <u>Bethesda, Md.</u>		29. ADDRESS (Street, city, town or county) <u>Bethesda, Md.</u>	
30a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		30b. DATE THEREOF <u>12-5-67</u>	
30c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		30d. LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>	
31. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		32. REC'D BY REGISTRAR <u>DEC 8 1967</u>	
33. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		34. ADDRESS (Street, city, town or county) <u>Bethesda, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7300

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>9902 Inglemere Dr.</u>	
3 NAME OF DECEASED (Type or print) <u>Robert C. MELENEY</u>		4 DATE OF DEATH Month <u>DEC</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>DEC 10-1915</u> 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical Eng</u>		11 BIRTHPLACE (County & State, or foreign country) <u>EVANSTON ILL</u>	
13. FATHER'S NAME <u>Robert C. MELENEY</u>		14. MOTHER'S MAIDEN NAME <u>STEPHANIE CLARK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16 SOCIAL SECURITY NO. <u>15-10-8415</u>	
17 INFORMANT (Name and Address) <u>JANE A MELENEY (wife) Same.</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>3561</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) <u>Acute Respiratory Failure</u>	
		(c) <u>AMYOTROPHIC LATERAL SCLEROSIS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>SEPT. 29, 1949</u> , to <u>DEC. 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>DEC 29, 1967</u> , and that death occurred at <u>11:52 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Robert G. Angle</u>		22b. DATE SIGNED <u>DEC 30, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		22d. ADDRESS <u>5009 Del Ray Ave. Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Jan 2 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Pr. Geo Md</u>
24. FUNERAL DIRECTOR <u>Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md</u>		25a. REC'D BY REGISTRAR <u>JAN 5 1968</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Certificate of Death (Son)											
17301											
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>-</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. + Hospital</u>						d. STREET ADDRESS <u>8219 14th Ave. apt. 102</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>Russell</u> Last <u>Miller</u>						4. DATE OF DEATH Month <u>December</u> Day <u>17</u> Year <u>1967</u>					
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>1-2-05</u>		9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rixon Electronics</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>		11 BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clayton Miller</u>						14. MOTHER'S MAIDEN NAME <u>Lavinia Pierce</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastrointestinal HEMORRHAGE</u> DUE TO <u>STRESS ULCERS OF STOMACH</u> (b) <u>PERITONITIS</u> DUE TO <u>?</u> (c) <u>WEEKS</u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HOMOLOGOUS SERUM HEPATITIS, CHRONIC BRONCHITIS, EMPHYSEMA</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21 I certify that (I) (this hospital) attended the deceased from <u>11-7-67</u> , 19 <u>67</u> , to <u>12-17</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12-17</u> , 19 <u>67</u> , and that death occurred at <u>7:40 AM</u> , from causes and on the date stated above											
22a. SIGNATURE <u>Leonard A. Deitz</u> M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12-18-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Leonard A. Deitz</u>						22d. ADDRESS <u>1111 SPRING ST. SILVER SPRING, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>12-19-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Univ. Med. Sch.</u>				23d. LOCATION (City or town) (County) (State) <u>WASHINGTON, D.C.</u>			
24. FUNERAL DIRECTOR <u>James E. Deibel - 2222 Wood Ave., N.W. - Wash DC</u>				25a. REC'D BY REGISTRAR <u>DATE JAN 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Clarence J. Deitz</u>					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17302

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL				d. STREET ADDRESS 1412 HAMPSHIRE WEST COURT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) BRENDA GAY MILLER				4 DATE OF DEATH Month 12 Day 8 Year 1967			
5 SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 6-29-45	
9 AGE (In years last birthday) 22 yrs		f UNDER 1 YEAR Months 12 Days 8		g UNDER 24 HRS Hours 19 Min 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11 BIRTHPLACE (State or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Miller				14. MOTHER'S MAIDEN NAME Loretta Layne			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. Yes		17 INFORMANT PEGGY ADER		Address SAME	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute, severe, bilateral, DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhagic, bronchopneumonia DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Read		EXAMINER'S NAME (Type) BELDEN R. READ, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED DEC. 8, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 12, 1967		23c. NAME OF CEMETERY OR CREMATORY Gardens Mountain View Memorial		23d. LOCATION (City or Town) (County) (State) Maher, West Virginia	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				ADDRESS Silver Spring, Md. 8434 Ga. Ave.		25a. REC'D BY REGISTRAR DATE DEC 13 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

1. 10/1/09

10/1/09

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17303

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Lynchburg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN IB <u>63 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Md.</u>		d. STREET ADDRESS <u>1000 Wise Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nellie Erna Millner</u>		4. DATE OF DEATH Month Day Year <u>December 27 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1921</u> <u>27 September</u>
9. AGE (In years last birthday) <u>46</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard G. Eagle</u>		14. MOTHER'S MAIDEN NAME <u>Pearl J. Phelps</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>227-22-9378</u>	
17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myelogenous Leukemia</u> DUE TO (c) <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>8 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>25 October</u> , 19 <u>67</u> , to <u>27 Dec.</u> , 19 <u>67</u> , that <u>X</u> (we) last saw the deceased alive on <u>27 December</u> 19 <u>67</u> , and that death occurred at <u>8:48 M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Bruce Chabner</u>		22b. DATE SIGNED <u>1967</u> <u>28 December</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bruce Chabner, MD</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>DEC. 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EAGLE FAMILY CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>APPOMATOX COUNTY, VIRGINIA</u>
24. FUNERAL DIRECTOR <u>WHITTEN FUNERAL HOME, INC. LYNCHBURG, VA.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17304

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in lb <u>7 days</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sen. & Hospital</u>		d. STREET ADDRESS <u>15105 Peach Orchard Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Elberta Milstead</u>		4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Care Home</u>	9. AGE (in years last birthday) <u>65</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Mills</u>		14. MOTHER'S MAIDEN NAME <u>Rosie Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>570-46-5191</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Widespread metastatic carcinoma</u> DUE TO (c) <u>Heart - Pulmonary + Osseous</u>			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-19-67</u> to <u>12-20-67</u> , that (I) (we) last saw the deceased alive on <u>12-19-67</u> , and that death occurred at <u>8:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Smith Jr.</u>		22b. DATE SIGNED <u>12-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith Jr. M.D.</u>		22d. ADDRESS <u>Burtonsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Dec. 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Burtonsville Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Burtonsville, Md.</u>
24. FUNERAL DIRECTOR <u>John R. Thompson & Son, Inc.</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Judge</u>			

CERTIFICATE OF DEATH

17305

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>20 days/23 hrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		d. STREET ADDRESS <u>1721 Merrimac Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium - Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALVIN ERNEST MITCHELL</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-99</u>
9. AGE (In years last birthday) <u>68</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Asheville, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Merrill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>578-10-6732</u>	
17. INFORMANT <u>William R. Mitchell</u> Address <u>1721 Merrimac Dr</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY		INTERVAL BETWEEN ONSET AND DEATH	
(a) IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>			
(b) DUE TO <u>CHRONIC COR PULMONAL</u>			
(c) DUE TO <u>PULMONARY EMPHYSEMA</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>67</u> to <u>12/6</u> , 19 <u>67</u> , and that death occurred on <u>12/6</u> , 19 <u>67</u> , at <u>8:30</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>D. N. Tublin</u>		22b. DATE SIGNED <u>12/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ira N. Tublin</u>		22d. ADDRESS <u>800 PERSHING DR. S.S. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges, County, Md.</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Arner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>	
25b. ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

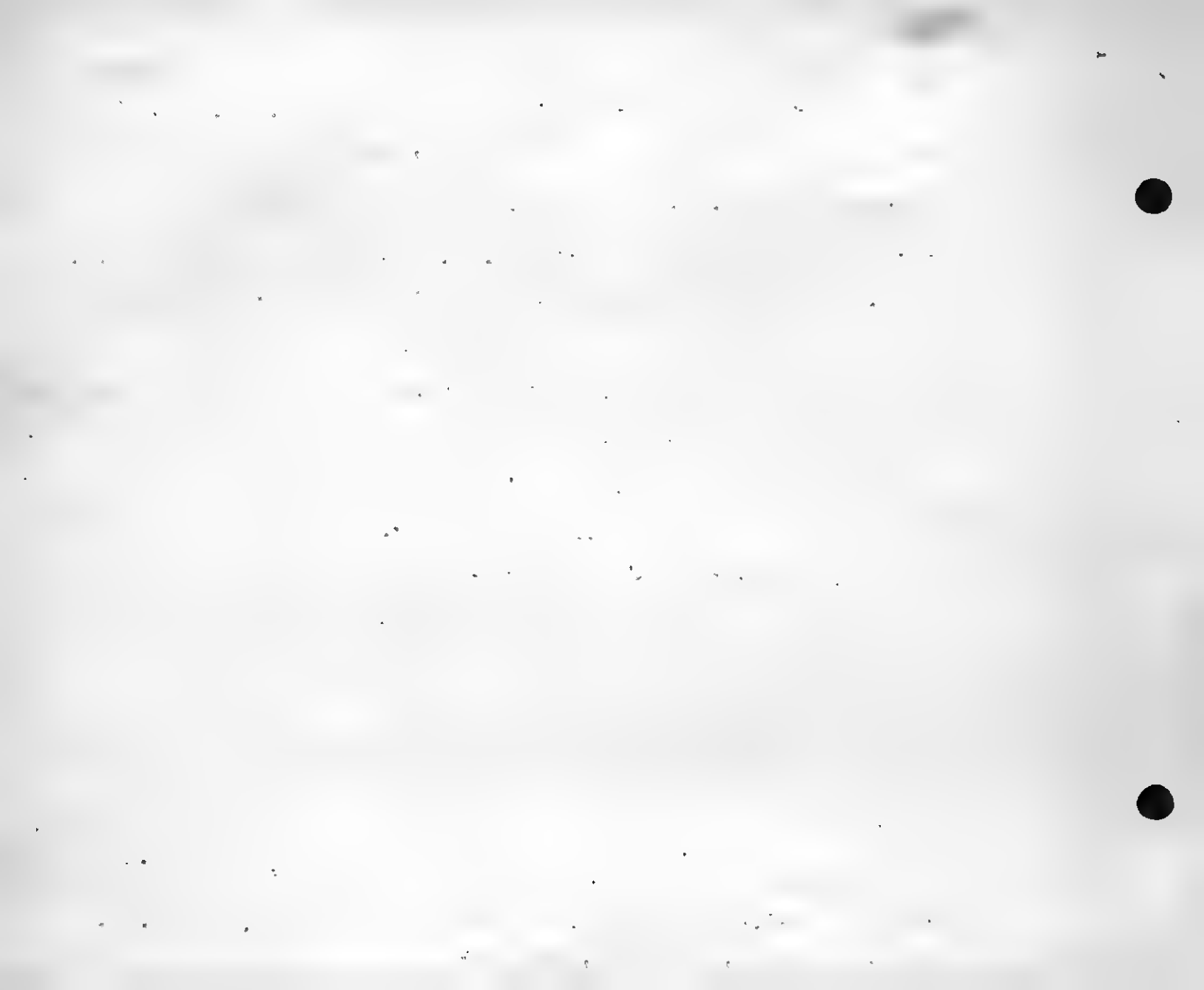
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
EDWARD GERARD MONTGOMERY						Dec. 20, 1967		10:12 P. M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		May 10, 1878		89 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Nebraska		U. S.				Montgomery		Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Rockville		Potomac Valley N. H.		Economist		U.S. Govt				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admision) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.		Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		24 W. Kirke Street		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
			Elizabeth Mooney							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address	
No			Unknown			Nancy Montgomery			Same as Item 13.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
(b) <u>Carcinoma of the</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Carcinoma of the Prostate</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Arteriosclerosis Heart</u>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M.								
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>										
22a I certify that (I) (this hospital) attended the deceased from <u>1961</u> , <u>1961</u> , to <u>Dec</u> , <u>1967</u> , that (I) (we) lost saw the deceased alive on <u>Dec 13</u> , <u>1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED		
<u>William H. K. H. A. Y.</u>								<u>Dec 21 1967</u>		
22d PHYSICIAN'S NAME (Type)				22e ADDRESS						
<u>William H. K. H. A. Y.</u>				<u>8218 Wisconsin Ave, Bethesda</u>						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		12-22-67		Rock Creek Cemetery		Washington, D. C.				
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
ROBERT A. PUMPHREY, Bethesda, Maryland				DEC 26 1967		<u>John J. Jones</u>				



CERTIFICATE OF DEATH

17307

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in b. <u>71 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Takoma Park</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7518 Carroll Avenue</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Pauline (none) Moore</u>				4. DATE OF DEATH <u>DEC. 7 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-90</u>	
9. AGE (in years last birthday) <u>77 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE Publishing</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Moore</u>		14. MOTHER'S M maiden name <u>Martha Barker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-348744</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET OF DEATH AND DEATH <u>12/7/67</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 22, 1937</u> to <u>12/7/67</u> that (I) (we) last saw the deceased alive on <u>12/6/67</u> and that death occurred at <u>3:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Edward T. Morsie</u>				22b. DATE SIGNED <u>12/7/67</u>		22c. PHYSICIAN'S NAME (Type or print) <u>Edward T. Morsie</u>	
22d. ADDRESS <u>7518 Carroll Ave Takoma Park Md</u>				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
<u>Burial</u>		<u>Dec. 9, 1967</u>		<u>Georgetown Cemetery</u>		<u>Adelphi Pk. Bld. Md</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Walters Washington, D.C. 20012</u>				25a. RECEIVED BY REGISTRAR <u>DEC 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						d. STREET ADDRESS <u>18825 Georgia Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>William</u> First <u>A</u> Middle <u>Moore</u> Last						4 DATE OF DEATH <u>Dec</u> Month <u>14</u> Day <u>1967</u> Year					
5 SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>11/3/1896</u>		9 AGE (in years last birthday) <u>71</u> yrs		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>		11 BIRTHPLACE (County & State, or foreign country) <u>District of Co.</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Moore</u>						14. MOTHER'S MAIDEN NAME <u>Helen Moore</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>579-20-1855</u>		17. INFORMANT <u>Helen Moore</u> Address <u>same as above</u>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA of prostate c spine, rib and liver metastases</u> DUE TO (b) <u>177X</u> DUE TO (c) <u>liver metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>0</u> m <u>p</u> m				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11-13</u> , 19 <u>67</u> to <u>12-14</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>12-13</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Benna G. Brender MD</u>						ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Benna G. Brender</u>						22b. DATE SIGNED <u>12-14-67</u>					
22d. ADDRESS <u>10820 Georgia Ave. Silver Spring, Md.</u>											
23a. BURIAL, CREMATION, <u>Burial</u> (Specify)				23b. DATE THEREOF <u>12/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodfield, Montgomery Md</u>			
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>1551 Rockville Pike</u>						25. REC'D BY REGISTRAR <u>DEC 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

17309

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17309

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 3 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4900 Battery Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last MARGARET B. MORGAN		4 DATE OF DEATH Month Day Year Dec. 4, 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1890 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Transit Co.	
11 BIRTHPLACE (County & State or foreign country) Washington, D. C.		2 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Michael Barrett		14. MOTHER'S MAIDEN NAME Catherine Shields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-10-6383	
17 INFORMANT Son John B. Morgan		7721 Marie Ave. La Mesa, Calif.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Decomp. with pulmonary edema DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerosis, generalised advanced. DUE TO Very (c) and multiple cerebral vascular thromboses due to advanced arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 hrs + 10 yrs + 10 yrs +
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction, old 1963 2) cholelithiasis, chronic			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY: Month, Day, Year - Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1955 to 12-4-1967 , that (I) was not saw the deceased alive on Dec 1 1967, and that death occurred at 12:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE Stewart Clapp		22b. DATE SIGNED Dec 4 1967	
22c. PHYSICIAN'S NAME (Type) Stewart Clapp		22d. ADDRESS 4740 Chevy Chase Dr Chevy Chase Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-7-67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 7 1967	25b. REGISTRAR'S SIGNATURE John A. Jones



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

17310

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17310

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEAT PLEASANT	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNIVERSITY NURSING HOME		d. STREET ADDRESS 712 Rollins Avenue	
3. NAME OF DECEASED (Type or print) JOHN BRYANT MORRISON		4. DATE OF DEATH DECEMBER 5 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 9, 1886
9. AGE (in years last birthday) 81 yrs		IF UNDER 1 YEAR: Months 5 Days 5 Hours 67 Mm	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY NURSERY	
11. BIRTHPLACE (County & State, or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN E MORRISON		14. MOTHER'S MAIDEN NAME MARY BRYANT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT EVELYN HEFLIN 407 ROLLINS AVE. SEAT PLEASANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) Arteriosclerotic Cardio - DUE TO Vascular Renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) 10 years (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1955 to Dec 5, 1967 that (I) (we) last saw the deceased alive on Jan 1, 1967 , and that death occurred at 5:30 PM , from causes and on the date stated above.			
22a. SIGNATURE William Brainin M.D.		22b. DATE SIGNED 12/5/67	
22c. PHYSICIAN'S NAME (Type) WM BRAININ		22d. ADDRESS 6124 Central Ave Capital Hill Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/8/67	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NAT. CEMETERY	23d. LOCATION (City or Town) (County) (State) SUITLAND, PRINCE GEORGES Md.
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME		25a. REC'D BY REGISTRAR DEC 11 1967	
4308 SUITLAND ROAD, SUITLAND, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

17311

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 10 Saddle Rock Ct			
3. NAME OF DECEASED (Type or print) Philip		First Philip		Middle O.		Last MORRISON	
4. DATE OF DEATH Month 12 Day 5 Year 1967		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5/2/09		9. AGE (In years lost birthday) 59 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Controller		11. BIRTHPLACE (County & State, or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Morrison		14. MOTHER'S MAIDEN NAME Leah Eisler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unk.	
16. SOCIAL SECURITY NO. 069-01-6574		17. INFORMANT Mrs. Anne Morrison (W) Ct. S.S. Md.		Address 10 Saddle Rock Ct. S.S. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure - Atherosclerotic Ht. Ds. DUE TO (b) Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gout, Diabetes, mellitus, Crohn's						INTERVA. BETWEEN ONSET AND DEATH 5 mo	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 , 19 67 to 5 Dec , 19 67 , that (I) (we) saw the deceased alive on 12/4 , 19 67 , and that death occurred at 11:4 AM, from causes and on the date stated above.							
22a. SIGNATURE Ira N. Tublin		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/5/67			
22c. PHYSICIAN'S NAME (Type) Ira N. Tublin		22d. ADDRESS 800 Pershing Dr. S. S. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-6-67		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		ADDRESS 3501 14th St. N.W.		25a. REC'D BY REGISTRAR DEC 6 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7312

7312

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH	Month	Day	Year	2b HOUR
Cora		Edna	Mowry		Dec	31	67	19	9 P M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD	Month	Day	Year
Female	White	28 Feb 1877	90 YRS	MONTHS	DAYS				19 M
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED		NEVER MARRIED	9 COUNTY OF DEATH				
Mich	USA	WIDOWED		DIVORCED	Montgomery		Md		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Kensington	Kensington Gardens		Housewife		at home				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER					
Md	Montgomery	Kensington	YES	10217 Summit Ave					
14. FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last		
Francis	E	Hadley	Mary					Foster	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
NO	213-56-3079		Ruth M Woolley		10217 Summit Ave				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, Bile</u>									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F. No		City or Town		County	State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from									
Natura causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASS STANT MED CAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED	
EXAMINER'S NAME (Type)		Belden R. Reap M.D.						1-1-1968	
23a BURIAL, CREMATION, or other disposal (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		Jan 6 1968		Wixon Cemetery		Wixon		Mich	
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Robert A Pumphrey				7557 Wisconsin Ave Bethesda, Md		DATE JAN 5 1968		Charles Judge	

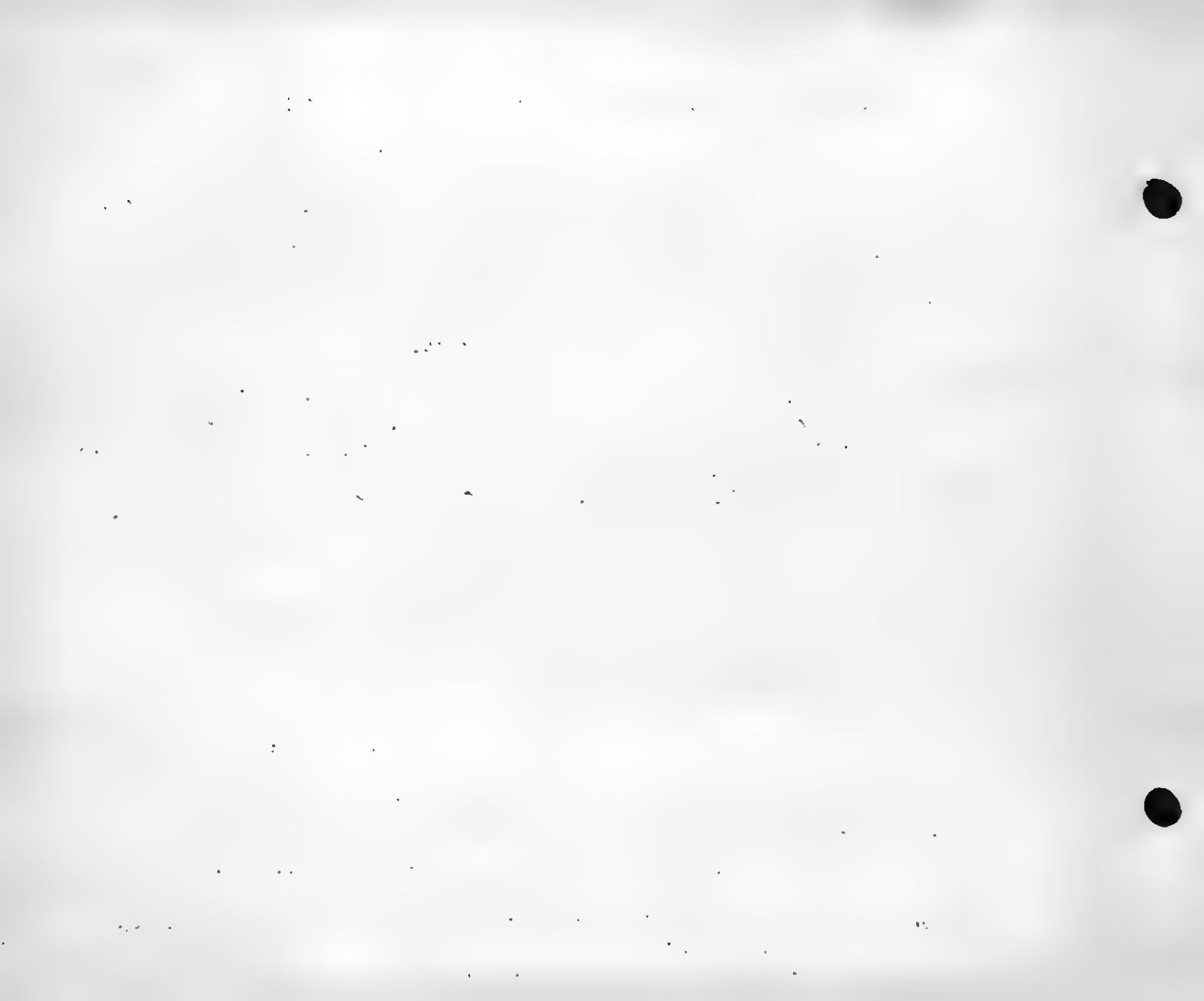
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

7313

1 DECEASED NAME (Type or print) First Middle Last Theresa Catherine Mulholland			2a DATE OF DEATH Month Day Year Dec 29 1967		2b HOUR M
3 SEX Female	4 RACE White	5. DATE OF BIRTH June 11-1899		6 AGE (In years at birthday) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Penn	7b CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md.		
10 CITY OR TOWN OF DEATH Boyd's Rural	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) house wife	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Little Creek	13b. COUNTY C	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER	
14. FATHER'S NAME First Middle Last John Hickey		15 MOTHER'S MAIDEN NAME First Middle Last Catherine Gorman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17 INFORMANT Address John Mulholland. Boyd's (Rural) Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> (metastatic) <u>lung?</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Stomach</u> <u>1 year?</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 15, 1967</u> to <u>Dec. 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec. 29, 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. - <u>10 1/2 pm.</u>					
22b SIGNATURE <u>Jack Schumacher</u> DEGREE ATTENDING PHYS				22c. DATE SIGNED <u>12-30-67</u>	
22d. PHYSICIAN'S NAME (Type) Jack Schumacher Md.				22e. ADDRESS Gaithersburg. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 1-2-68		23c. NAME OF CEMETERY OR CREMATORY Bradock Catholic	
23d. LOCATION (City or Town) (County) (State) North Bradock Ala. Penn		24. FUNERAL DIRECTOR Ernest C. Gartner ADDRESS <u>Ernest C. Gartner</u> Gaithersburg. Md.			
25a. REC'D BY REGISTRAR DATE <u>Jan 3 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE HEALTH DEPT.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chever Chase Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Edgar Murdoch</u>		4. DATE OF DEATH <u>30 Dec 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18th 1924</u>
9. AGE (In years last birthday) <u>43</u>		10. UNDER 24 HRS. IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>John Hop & Co. Inc. Frederick, Md.</u>	
11. FATHER'S NAME <u>John Edgar Sr.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. MOTHER'S NAME <u>Sara Lynch</u>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, if unknown) (If yes, give war or dates of service) <u>Yes MD-418 DDN-03700</u>	
15. INFORMANT <u>Same</u>		16. ADDRESS <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <u>Multiple Injuries. Severe -</u>			
DUE TO <u>Trauma from Auto Accident -</u>			
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Had epileptic seizure while driving -</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:00 pm 12/30 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Bethesda Montgomery Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>12/31/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL (CREMATION, REMOVAL (Specify)) <u>Burial</u>	23b. DATE THEREOF <u>1/3/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., Wash., D. C.</u>		25a. REC'D BY REGISTRAR <u>JAN 5 1968</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FILE 8 D.O.B. SEPT. 1, 1924 - 43 YRS.

CERTIFICATE OF DEATH

17315

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN It 2 Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNH, NMMC, BETHESDA, MD		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 4819 Longfellow St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Henry Murphy First Middle Last		4. DATE OF DEATH December 16 19 67 Month Day Year	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 MAR 84 9. AGE (In years last birthday) 83 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy, Ret. GMC		10b. KIND OF BUSINESS OR INDUSTRY Civilian Engineer	
11. BIRTHPLACE (County & State, or foreign country) New York, N. Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Joseph MURPHY		14. MOTHER'S MAIDEN NAME Mary E. HOGAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1905-1922		16. SOCIAL SECURITY NO 578 01 0219	
17. INFORMANT Gladys C. MURPHY		Address Same as 2D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO 1200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 14 SEP , 19 67 , to 16 DEC , 19 67 , that (I) (we) last saw the deceased alive on 16 DEC , 19 67 , and that death occurred at 1840H , from causes and on the date stated above.			
22a. SIGNATURE Robert J. Kinney M.D.		22b. DATE SIGNED 17 DEC 67	
22c. PHYSICIAN'S NAME (Type) Robert J. Kinney, LCDR, MC, USN		22d. ADDRESS U. S. NAVAL HOSP., BETHESDA, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 20, 1967	23c. NAME OF CEMETERY OR CREMATOR Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Virginia
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DEC 21 1967	25b. REGISTRAR'S SIGNATURE Wm. J. Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN TB 10 Days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital			d. STREET ADDRESS 14701 Peach Orchard Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) ETHEL WRIGHT MUSGROVE		4. DATE OF DEATH December 29 1967		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/12/03	
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter G. Wright		14. MOTHER'S MAIDEN NAME Anna Duvall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Medical Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 170X PULMONARY CONGESTION DUE TO (b) GENERALIZED METASTASIS DUE TO (c) CARCINOMA BREAST		INTERVAL BETWEEN ONSET AND DEATH 6 DAYS MONTHS 20 Month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CARCINOMA ENDOMETRIUM					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Aug 12/68 , 1967, to 12/29/67 , that (II) (we) last saw the deceased alive on 12/28/67 , and that death occurred at 11:45 AM causes and on the date stated above.					
22a. SIGNATURE Donald R. Lewis		22b. DATE SIGNED 12/29/67		22c. PHYSICIAN'S NAME (Type) Donald R. Lewis, M.D.	
22d. ADDRESS 700 Cloverly St. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 1-1-68		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
23d. LOCATION (City or Town) (County) (State) Burtonville Md					
24. FUNERAL DIRECTOR De Witt Donaldson Laurel Md		25a. REC'D BY REGISTRAR JAN 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 12 Film G396 1/3/68 KK

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>Shore Acres</u>	
3. NAME OF DECEASED (Type or print) <u>Rosa</u>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> / NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/83</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Sicily</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Salvatore Di Pietro</u>		14. MOTHER'S MAIDEN NAME <u>Concetta Giglio</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Joseph DiPietro</u> Address <u>Shore Acres, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE KIDNEY</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BILATERAL LOBULAR PNEUMONIA</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> , 19 <u>67</u> , to <u>12/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> , 19 <u>67</u> , and that death occurred at <u>11 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Pollen</u>		22b. DATE SIGNED <u>12/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN MD</u>		22d. ADDRESS <u>10400 CONNECTICUT AV KENSINGTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Witzke & D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR <u>DEC 26 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE	

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